

# BLOOD, SOCIETY AND THE GIFT: AN ETHNOGRAPHY OF CHANGE IN THE GIFT RELATIONSHIP

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by

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## **Abstract**

Commentary about solid or whole body part transplantation, transfusion and donation is well documented and has added to discourse about who gives and receives and how. Commentary about another body part – blood – is, it is argued here, less well developed (Sanner, 2001; Lock, 2004; Scheper-Hughes and Wacquant, 2006; Shaw, 2009). Blood and its modern-day sociology and anthropology is understood and limited by its links with both Titmuss' altruism and gift exchange theories. This thesis, using a qualitative ethnographic approach, re-examines and introduces new discourse about blood, challenging the orthodoxy of altruism and seeking new understanding and justification for blood donation. It uses testimony from 80 blood donors to elicit real-time ideas about blood as a source of risk rather than a gift from strangers. It also argues that donors “give to get back” their donations rather than give as a form of altruistic behaviour, thus introducing the concept that blood donating is a form of covenant between society and the individual or a form of deposit.

Issues of trust are examined via the lens of deferment as increasingly it is not good enough to just donate blood without stringent societal, as well as techno-medical, surveillance. Donating blood is shown to be a form of active citizenship, and to be deferred from doing so has a direct impact on individuals' freedom to donate and thus community membership. The emotional labour of giving is revealed by the testimonies of “able” donors, which evidence that not only do donors perceive their blood to be special, but also the act of giving is a labour carried out by the few who can do it for the majority, in contrast to those donors who regard giving blood to be a mundane, functional practice. Lastly, an emerging hierarchy of self in relation to the body is uncovered here revealing hints at its' inalienable status. The thesis charts the journey of blood from being a mystical part of the body, linked to goodness, to blood being the new “master tool” of modern society, imbued with risk and therefore entrusted to society via scrutinising blood management systems. The methodological framework is centred on an interpretative approach, using data gathered from interviews and questionnaires from active blood donors in sessions at the National Blood Service (NHSBT) as well as testimony gathered from individual one-to-one interviews. It refers to theories by Foucault, Mauss and Douglas to interpret the qualitative data revealing blood as a target of bio-power, risk management and social exchange and a shifting dislocated new body part, and it sets out to challenge the orthodoxy of altruism as the rationale and justification for blood donation in modern Britain.

**Keywords:** blood donation, blood, gift relationship, gift exchange, body parts commoditisation, altruism, risk, deferment, bio-medicalisation, surveillance, citizenship.

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“The body is man’s first and most natural instrument. Or more accurately, not to speak of instruments, man’s first and most natural technical object, and at the same time technical means, is his body.” (Mauss, 1979)

“Anyway ... one day you may need it yourself.”

Simon (blood donor), 4 September 2007

# **Chapter 1 Introduction**

## **1.1 Introduction**

This thesis is about blood. In echoing Titmuss (1997), blood, it is argued, remains a metaphor for societal relationships. This is why it is the focus of this thesis. The topic of blood has, in particular, been a focus of anthropological research with regard to kinship systems and lineage (Strathern, 1992; Radcliffe-Brown and Forde, 1952; Holy, 1996). But, moving beyond a solely anthropological focus, conceptions of blood and blood donation can also be understood with reference to sociological conceptions of societal change. This thesis focuses upon blood, blood donors and the transformation of blood symbolism with reference to such social change. More specifically, the research is concerned with changes in understandings of blood and how blood donation is viewed with reference to risk, citizenship and body commodification in contemporary British society. The thesis challenges and extends a dominant explanatory paradigm of unpaid blood donation in England, that based on altruism.

Blood, it is argued, can indeed symbolise expressions of citizenship and affiliation, but it can also act as a focus of real and imagined risk and as an object through which attempts to control such risk are enacted. This chapter first places the research in

immediate academic context, as a pre-cursor to more detailed exposition, and then outlines the rationale and aims of the thesis. This is followed by an outline of the purpose and content of subsequent chapters.

## **1.2 Background, aims and approach to the research**

I became interested in the relationship between the body and society through earlier academic research. I had examined another body fluid, breast milk, from an anthropological perspective in order to put forward explanations for why the UK has a relatively low breastfeeding rate (Mahon-Daly and Andrews, 2002). In so doing, I became aware that only 5% of those eligible to donate blood in the United Kingdom do so (NHSBT, 2011). Emerging work in the sociology and anthropology of the body in relation to body part donation suggested that there was analytical scope to explore and perhaps develop Richard Titmuss' seminal work on blood donation in *The Gift Relationship* (Titmuss, 1997 [1970]). Indeed, initial reading suggested that much anthropological and sociological work on blood donation appeared just to affirm or focus upon his idea of altruism as a basis for giving.

More detailed examination of the literature suggested, however, that blood, body commodification (Lock et al., 2010) and risks to the public health (Larsen, 2007) have served to augment blood as a multivalent symbol. Blood is simultaneously a metaphor, a body part and a pharmaco-medicinal substance in modern-day Western society; an object of multiple roles and symbols. Starr (2002:46), for example, argues that blood has become an entity in its own right, sitting in the middle of society and about which different people have different views. The significance of this observation has increased

markedly in recent decades. Blood has more recently been framed with reference to risk as a result of the emergence of new blood-borne viral infections that have been felt by vulnerable social groups such as haemophiliacs, but it has also generated wider public disquiet (Healy, 2008). Most notably, the emergence of the Human Immunodeficiency Virus (HIV) and new variants of hepatitis, coupled with initial failures by the National Blood Service (NHSBT) to protect the blood supply, have generated public alarm and have raised issues of citizenship to blood donation.

There was thus scope for new research and reflection on the nature of blood donation by relatively few individuals in return for no obvious reward. In this light, the aims of this doctoral research were: a) to investigate and expose prevailing beliefs and cultural practices with regard to blood; and b) to understand reasons for the changed behaviour and motivation of donors who provide their body and blood, free of charge, for the wider population. These aims would come to be reflected in three organising themes:

1. to use research evidence to confirm, discount or develop the explanation of altruism as a basis for voluntary and unpaid blood donation that was encapsulated in Titmuss' *The Gift Relationship*;
2. to indicate, on the basis of research evidence, the impact of developments in biomedicine, consumerism and the "risk society" with regard to blood, blood donation and blood products;
3. to explain, on the basis of research evidence, the changing meaning of blood donation as a cultural symbol in contemporary British society.

This implicit focus upon beliefs and reasons with regard to blood donation and its conceptualisation also served to shape the epistemological and methodological approach to be taken in the research. As Geertz (1993) argued, an interpretative approach based on the accounts of key actors in a given context is essential to determining situated “meaning”, and the detailed “thick” description of actions within particular social settings can provide an insight into the basis of situated cultural practices. Against this background, the research reported in this thesis re-examined the relationship of blood to the body, society and those who donate in the United Kingdom through the use of interviews, ethnographic observation and documentary analysis in selected fieldwork sites. 80 unstructured face-to-face interviews during periods of observation were conducted on the basis of self-completed questionnaires distributed to people who donated blood at NHSBT sessions in selected English Home Counties. Additional data was gathered from donors who talked to the researcher outside the formal sessions, the NHSBT staff at the sessions and a small group of informants who participated in the pilot research.

### **1.3 Structure of the thesis**

Chapter 2, “Historical Context – The Rationalisation of Blood: Blood as Science”, begins with a historical account of social and medical conceptions of blood. The chapter lays the foundation for the thesis by charting the concepts of biomedical management of the body and, more specifically, the rise of blood as a part of the body to be managed and rationalised by the emerging political state (Weber, 1964). Seminal work on the anatomy of blood is described and related to the transformation of blood as a religious

symbol to an emblematic focus of the emerging primacy of biomedicine. The chapter also describes a pivotal event, successful human blood transfusion, and relates this to the subsequent harnessing and management of blood by the medical profession. The history of the institution that later came to manage blood donation, the NHSBT, is revisited for significant events (such as the first planned public donation sessions) and in relation to the emergent paradigm of altruism as a basis for blood donation in British society.

Chapter 3, “Literature Review”, is an analysis of the relevant literature in relation to the intended scope and objectives of the thesis. The chapter outlines the analytical framework and contemporary debates concerned with blood and blood donation. In particular, it examines the theories related to altruism, gift exchange, risk theories and citizenship.

Chapter 4, “Methodology”, presents the epistemological and methodological framework that underpinned the research design and data collection. The first of these, Chapter 5, “From Gift to Risk: Challenging the Orthodoxy of Altruism”, focuses on the findings as they relate to ideas about blood as a safe, clean “gift” and more contemporary perspectives pertaining to risk. The sixth chapter, “Deferment and Citizenship: Too Risky to Give”, interprets the data with regard to issues of risk as they relate to views on who can or cannot (and should or should not) donate blood. Particular themes therein centre on risk management, moral panic and the links between moral suitability as well as eligibility to donate. Chapter 7, “Giving to Get Back: From Altruism to Covenant”, examines the findings in relation to motives for donation, changing conceptions of risk, citizenship and deferment. This chapter, in particular, challenges the idea of altruism as

the key motivation for blood donation. The findings instead investigate the concepts of a covenant between the giver and society, the role of attitudes towards family in contemporary blood donation, the personalisation of risk management and challenges the idea of inalienability (Weiner, 1992). Chapter 8, “Blood Donation, the Body and the Self”, draws on the findings as a whole to argue for a link between the biomedicalisation of the body and the creation of a self-ascribed “hierarchy of the self”; an idea that explains a new or developing relationship between society and the individuated body/self and proposes that donated blood has as a result of the biomedicalisation process become alienable. The concluding chapter first addresses the initial research aims, the efficacy of the research design and research methods. It then turns to the implications of the findings for future research and conceptual work on blood donation.

## **Chapter 2 Historical Context – The Rationalisation of Blood: Blood as Science**

### **2.1 Introduction**

Prior to presenting the fieldwork, it is important to understand the history of the substance, blood itself, in relation to the social processes which in turn shaped blood as emblematic of science rather than faith and religion. Thus the purpose of this chapter is to present a history of blood, examining it as once a symbol of kinship and godliness to becoming a metaphor of change in the UK, and to create a historical context for understanding the processes and technological developments which created the capacity to transfuse human blood and thus create the changes associated with gift, risk and social relatedness, which the subsequent chapters examine, starting from the legacies of the largely Galenic system (c.129–199AD), which characterised the mid-sixteenth century body management, and seeking understanding of blood in relation to the Enlightenment and subsequent rationalisation and medicalisation of society. It traces blood's journey in society following industrialisation and the developments that created the conditions leading to human-to-human transfusion and medical professional dominance of blood.



This presents the view that as society became rationalised so did blood and it is argued here that blood became “science”. This starts the process of the separation of blood from the body and its relocation into the clinical domain and away from the religious hegemony.

## **2.2 Enlightenment and blood**

As the prevailing pluralistic medical systems changed under the impact of science and the Enlightenment, the circulating knowledge about blood, and how blood was formed in the body and how it affected the workings of the body and how it could be transfused from one person to another also altered. The impact of these scientific events, as I will show in later chapters, is directly linked to the contemporary location and metaphors of blood in society today; for example, blood has become, it is argued, a new symbol of bodily risk and of social indebtedness, and emblematic of biomedical hegemony.

The impact of the Enlightenment in the late eighteenth century gave rise to what became known as biomedicine (Stacey, 1988) in Europe as the prime source of bodily management and advice and brought blood under the scrutiny of science (Armstrong, 2003). B Turner (2001) has argued that the rise of the professions sought mastery of the flesh at this time, but in reality it is argued here that it was more specifically the mastery of blood which brought the body and the new diseases under medical rather than religious control. Blood was the visible focus of the resultant power struggle.

The Enlightenment and subsequent “rationalisation of man” (Weber, 1964; Elias, 2002) were important landmarks in the shift of man away from nature into culture. Rationalisation encompassed ideas about secularisation, intellectualisation and

systematisation of the everyday world (Gane, 2002:5), thereby creating a dichotomy in society in ordinary people as well as in the intelligentsia about what to believe. Blood is a critical example of this dilemma, as this chapter will illustrate. Blood, it is argued here, through the processes of enlightenment and rationalisation became at first secularised, then rationalised in a similar way, challenging old ways of understanding blood and its role in the body. Enlightened thinking required the population to question the old ways of understanding the individual in relation to the emerging new governance via government instead of the monarchic and church mediated control (B Turner, 2003). More important for my argument is that this process of rationalisation required new understanding of how their bodies related to the new governance, how the new bodies related to the person, and the emergence of the sick man (Armstrong, 1995; Earle et al., 2009). This is relevant to ideas of the self in relation to blood as discussed in Chapter 8. By focusing on using the body and the new culture of science, the social control of society came from the new order as opposed to the old religion-mediated societies (Giddens, 2009). The resultant shift in regarding blood as an external rather than internal substance was vital in the subsequent understanding by the public that medical doctors could control blood by either taking it out of you or prescribing substances to thin or thicken it. In effect the rationalisation of blood occurred as a prelude to the subsequent medicalisation.

The scientific discoveries of the Enlightenment in terms of knowledge related to human physiology revealed that blood had in fact a defined circulation route within the body, and that it could replenish itself when shed; these were important landmarks in the

development of blood's relation with the newly emerging governmental state order (Winner, 2007) and began the challenge to the traditional way of understanding blood.

The subsequent remapping of the human anatomy challenged the prevailing ethno-physiology of the time, and by using blood as a metaphor we can usefully illustrate the social changes at this time. In 1667 a leading anatomist, Nicholas Steno (1638–1687), gave a lecture on anatomy, arguing: “The brain is the main organ of the soul”. Steno was at the forefront of the new medical world, progressing methods of dissecting the body and micro-anatomy, but at the same time he juxtaposed the new knowledge within the context of the prevailing religiosity of the time. When discussing early ideas about the cause of mental illness, Steno talked about the blood having “Animal Spirits in it”. Robert Boyle, a pre-eminent medical doctor at the time and founder of the Royal Society of Medicine, went further suggesting that: “The logic of the body was natural rather than divine” (Arikha, 2006:158). The coexistence of two competing paradigms about the physiology and anatomy of the body was in part solved by the subsequent experiments with blood transfusion, which are discussed later in this chapter.

Foucault (1977) argued that blood was a valid target of power within what he termed the “docile body”. The blood in the late eighteenth century could be further identified as “docile”. The body, according to Foucault (1977:136), had been the subject of control in the classical age as an object and target of power. I would argue that the blood itself was the essential target of these “new micro-physics of power” (p.139), due to the early transfusionists and country doctors who were experimenting with transfusion to great celebration (Titmuss, 1997:63). Blood, as well as the body itself, began to develop a political anatomy at this time, which is present and developing today with the

emergence of the state, not the monarchy, as the control mechanism of societies. The state sought to control its populations via the body. The body and blood were thus constructed as objects for social control. The demise of monarchic and religious management of the blood coincided with this. Foucault (1977:138) has argued that the body became; “Manipulated, shaped, trained”, metaphorically comparing it to the army. Through this control the body became more docile. Foucault’s further argument about the body can be extrapolated to blood. He argues that: “A body docile may be subjected, used, transformed and improved.” This process has also happened to blood itself.

The blood through the emergent “medical gaze” had become docile, and the new relationship biomedicine forged with the blood rather than the body itself ensured: “The formation of a relation that in the mechanism itself makes it [blood] more obedient as it becomes more useful and conversely.”

Increasingly, by the middle of the eighteenth century, the actual body and not the spirit became the focus for the medical doctors. The consultation consisted of an inspection of the blood, urine and other fluids produced by the body, and on the patient’s description of his or her symptoms. As blood was the most visible part of a sick body, this component became increasingly the one that both doctor and patient relied upon to develop the role of prime medical practitioner by describing aspects of blood such as its consistency and colour where it was emanating from within the body. Blood became the first body part to fall under what became later known as the “the gaze” (Foucault, 1977). Moreover, we can now extrapolate this to argue further changes within the doctor–blood relationship in contemporary Britain, in that visible inspection of blood has become replaced by an inspection at cellular and particle levels. Foucault’s medical

gaze has, in relation to blood component therapy, reached particle level. These changes can also, according to Armstrong (1995:394), be the turning point where bedside medicine became hospital medicine because it relied not only on the symptom of the patient, but also on the increasingly scientific “sign” only the biomedical practitioner could recognise.

However, actual physical examinations were rare; patients rarely took their clothes off due to societal rules of modesty. The examination was dependent on references to the body and blood, portrayed in diaries (e.g. McFarlane, 1991). Descriptions centre on the eruption of lesions on the skin, the movement of fluids through the body, and the problems caused by any blockages with the metaphor of the body being infiltrated by badness. Blood can be seen as a metaphor of the Devil in this time. Releasing the danger was through the practice of bloodletting. Many records and images of doctors performing “letting” exist.

### **2.3 Humoral control of the body**

Humoral medical systems are well known, but a reprise is useful to provide context in how the Enlightenment affected blood. Humoral medicine was practised from ancient and medieval times. It is based on the concept of four body humours or substances. As a result of the neo-classical revival following the Enlightenment and the translation of the Galenic text *On the Conduct of Anatomies* in 1530, humoral medicine dominated the emergent medical practice, which resulted in subsequent tension and misunderstandings as to how the body worked and how to cure it. The key difference, according to B Turner (2001:290), was the body. In the Galenic paradigm the body was not examined,

but as scientific practice of medicine emerged pathological anatomy challenged the humoral belief system. Blood was arguably the first point of difference.

Foucault, in *The Care of the Self* (1990:108), described the humoral system as a sort of pressure system which under stimulation would build up and require a sudden evacuation from the body to bring back the appropriate balance. Humoral derives from the word “humour” which means “fluid”. The human body was thought to contain a mix of the four humours: black bile (melancholy), yellow or red bile, blood and phlegm. Each individual had a particular humoral makeup, or “constitution”, and health was defined as the proper humoral balance for that individual. An imbalance of the humours resulted in disease. The balancing of the humour was the domain of the medical doctor in conjunction with the environment and the church, the aim being to keep the body in harmony.

Between the sixteenth and eighteenth centuries, the humours were also used to refer to four individual psychological temperaments: melancholic, sanguine, choleric and phlegmatic. This reflects the humoral concept that physical health and individual personality were part of the same whole. This paradigm being understood and practised today is evident in language use related to disposition, e.g. phlegmatic.

The development of humoral theory is associated originally with Hippocrates (c.460–370 BC). In the second century AD, Galen elaborated on this theory, which was further developed by Arabic writers beginning in the ninth century and by European writers beginning in the eleventh. It remained dominant among both physicians and the public through the eighteenth and nineteenth centuries until the model was successfully challenged by the discovery of microbes, which is described later in this chapter.

The humoral theory was popular with patients and doctors as it allowed the doctors to illustrate two new ideas: the potential “badness” of blood and their developing special biomedical knowledge. This was done by performing a process known as titration. This is when the doctor withdrew differing amounts of blood from the body using embryonic medical equipment in order to restore the humoral balance with the demonstration of it through the practice of bloodletting. The artery was cut and the blood simply drained out by gravitational forces. This related bodily health to whether the person had enough or too much blood, and therefore viewed blood donation as a form of therapeutic bloodletting.

The Humoral system was a complex system linking the body to the environment. Each Humor was further associated with one of the four seasons, and each was considered to have characteristic qualities of hotness, coldness, dryness, and wetness. Because each individual’s humoral balance was holistically connected with other phenomena – such as climate, diet, occupation, geographic location, planetary alignment, sex, age and social class – what was healthy for one person might not be so for another. This idea of hot and cold is evidenced in recent medical anthropological literature (Helman, 2004; Nichter and Kavat, 1998; Farmer, 1998). Humoral treatments, or “regimens”, were designed to restore the proper balance by bloodletting, emetics, enemas, and other purges, and they were accompanied by diet and lifestyle changes and by medications that were based on a person’s disposition or humoral make-up. Illustration of the power of this system can be seen today. Eysenck (1985) utilised humoral theory to outline his personality types theory, arguing that the body type was analogous to individual psychological make-up using the same typology.

Thus seeing blood as a vector for explaining unusual or what was increasingly regarded as anti-social and changeable behaviour (e.g. fevers and bizarre mental states) became a powerful part of the emerging physician's repertoire as an agent of state control in the early eighteenth century. The new physicians increasingly turned to blood for reason and cause of sickness as opposed to sinful behaviour. This was evidenced by the discovery of bacteria and micro-organisms in blood as a result of the invention of the microscope by De Leuwenhoek in 1676. This was added to by the developments in dissection techniques of the dead body. Foucault (1977) has argued that the growing use of dissection, especially of criminals, was related to the growing power of the law to control bodies and created tension in relation to the sanctity of the dead body versus the need of the scientific anatomists to know.

In humoral theory, individual diseases were not conceived as we conceive them now. Neither diseases nor malady nor errant behaviour were seen as forces or entities separate from the body; they were understood as states of bodily imbalance, and in this review of the historical changes in meanings attached to blood, it may also be interpreted by me as a "blood" imbalance. This is because it is the blood that was the actual focus of the cause of the behaviour rather than the body.

In relation to the interest in the dead body and the rise of dissection, a further development which is relevant to interpret here is the relationship of blood with the later to be crucial practice of what could be regarded as early forms of examination. The more "scientific" the doctor, the more likely it was that a physical examination would be instigated. Physicians trained in humoral theory relied not only on knowledge of



quasi-medical texts emanating from earlier times, but also on an ever-increasing level of physical contact with the sufferer.

## **2.4 Vitalism**

As a result, bloodletting acquired its own name, “vitalism”, and was practised with the aid of a plethora of equipment such as bloodletting lancets and bowls. Medical doctors would design their own variants of this equipment, thus customising the quasi-scientific skill. Blood was taken out in varying amounts, ounces at a time. The amount and where in the body it was taken from was a clinical judgement. Bloodletting was both a drama and dramatic. It placed the medical doctor in direct contact with the sufferer and relied absolutely on the reputation of the doctor performing it. The reactions to bloodletting ranged from a feeling of dizziness to actual collapse and death.

Dying from loss of blood was not uncommon and appreciated to be a consequence of the disease rather than iatrogenic. The ethno-physiology of blood at this time was indistinct and as a result doctors were entrusted with the practice for much longer than the procedure deserved. Bloodletting was instrumental in positioning blood at the centre of the newly science-led society (Schmidt, 2002; Learoyd, 2006; Alter and Klein, 2008).<sup>1</sup>

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<sup>1</sup> [www.bloodbook.com/trans-history.html](http://www.bloodbook.com/trans-history.html) 060710

## **2.5 Harvey and the discovery of blood circulation – Circulation theory and transfusions: From sin to sickness**

The work of Harvey in 1667 contributed to the new ways of understanding bodily events and how blood circulated the body and created a “new magic” (Buckley and Gottlieb, 1988) of blood, and by doing so introduced the concept of mechanical man; the heart became a mechanical object rather than the source of feeling and goodness. Harvey used the new empiricism to prove that blood circulated the body and there was an intricate valve network which prevented the blood from back flowing. The new knowledge provided a further avenue for doctors to take control of the body as well as being able to take blood out of the body. The new understanding of how the vein network functioned allowed the first forays into developing potions and medicines to put into the body directly. Harvey’s discoveries put humoral physiology under scrutiny, but the battle for the truth about the source and make-up of blood was long. In the seventeenth century, beliefs about the body and blood were firmly entrenched within not only the Galenic but also the Aristotelian belief systems. These worked well to satisfy the “scientists” of the day as well as both religious and lay public. The system of medicine was fully credible – entrenched and reinforced in the language of the day.

Arikha (2008) charts the competition for control of this status. She examines this pivotal point in time for blood. It is the first time that the human body was treated as a mechanical object – and the blood as a circulating fluid within. This, of course, was an echo of the surrounding mechanisation which accompanied the industrialisation of the world at this time (Gold, 2007). Scientific discovery was entering all realms of previously accepted and unchallenged knowledge. Little by little the humoral hegemony

began to be challenged. The very relationship humans had with nature, evolution and the church was being questioned around the globe. The juxtaposition of publication of Burton's "Anatomy of Melancholia" and Harvey's "Anatomical Essay Concerning the Movement of the Heart and the Blood in Animals" (1628) only seven years apart illustrates the pace of challenge to the humours as received truth about how the body functioned. Harvey's essay was based on a new paradigm – based on lectures in 1616 to the College of Physicians. He became a doctor in St Bartholomew's, situated at the literal site of the battle for the body at the epicentre of the new scientific evidence-based regime.

In trying to communicate this new knowledge, Harvey himself referred to the humoral cosmology of blood, despite his experiments being directly responsible for the final death knell of the humoral lay belief system. He sought refuge in the repetitive scientific practice of experiment as a valediction of his new truth.

As well as being the first to use mechanical metaphors in relation to the heart – "a pump-like muscle" – the essay "The Movement of the Heart" challenged the understanding about how and where in the body blood originates from. Harvey argued that it was impossible for the liver to be producing blood as it did other humours, because the heart was unable to process blood from the ingested food, as the beating of the heart was a continuous process.

Harvey's work was central in creating a new way of understanding blood. His work revealed that there were two circulations, in effect two bloods: one going to the heart, and a new type of blood coming back out from the heart.

## 2.6 Blood and gore

Harvey's experiments proving that blood "circulated" in the body for oxygenation via the lungs was in direct opposition to the Galen and Hippocratic traditions. Following this discovery, both the heart and blood had newly ascribed functions which had an impact on the symbolic meaning and beliefs previously given to blood. This was, of course, difficult to re-orientate overnight.

Harvey himself was a victim of continuing to use humoral explanations for blood formation and the disease processes, underlining the level to which the theory of humour was the truth about healthiness as well as personality. He still used descriptions about blood that were reminiscent of the Galenic system, e.g. "native heat" or "innate warmth", and in discussing "the natural spirits of the blood" he argued that they were no more separate from the blood than is a flame from its flammable vapour: the ideas persisting, therefore, that blood was more than a fluid. Further, he held on to the idea that blood had a relationship with a person's spirit, using a metaphor relating the spirit and blood to the wine itself and the bouquet it gives. One of the most persisting ideas about blood which emanates from this time is the debate Harvey initiated about "gore". This notion is easily identifiable in contemporary discourse about blood. The adjective "gory" is used today to describe a situation when there is too much blood, blood soaked or blood spilled in a bad way. It is therefore a negative connotation of blood, thus proving that early properties ascribed to bad blood still exist in common parlance.

Harvey's definition or description of blood was to continue to employ the wine metaphor. His definition of "gore" was of blood that had "gone off", or wine left open

for too long. Harvey even differentiated between blood going to and from the heart as having different qualities or attributes. The arterial blood had more “spirit” in it and returning blood was gore – the bouquet or spirit having gone out of it. Of course these metaphors are quasi-religious, “spirit” being a reference to the by-product of godliness. This was indicative of how embedded the humoral paradigm was. Harvey further linked the gore as a sort of air-borne entity, which had ramifications in later times as the next system of managing illness evolved.

## **2.7 Miasma, germ theory and contagion**

The other dominant theories of illness and sickness causation are grouped around miasma and germ theories, which circulated in the sixteenth and seventeenth centuries. The emergence of germ theory further consolidated blood as a socially important fluid in that medical practice could examine the blood itself for germs. It consolidated the new blood of Harvey into a public rather than individual bodily element, which was capable of giving and catching disease. The link between bodily behaviour and immorality which had upheld the religious control of deviance was threatened (Stacey, 1988). This was the first process in the relocation of blood as a life-giving substance, as opposed to its being seen as only one of the humoral constituents of the internal body (Armstrong, 1995).

The leap from blood causing sickness from within the body to its being linked to the air was critical to the future of blood as an entity in its own right requiring professional management. This could be described as the blood becoming a live organism capable of fighting the body in which it was housed. The simplistic relationship between the body

and blood became open to reinterpretation as the impact of the Enlightenment and rationalisation progressed. The concepts of causation in relation to illness made a quantum leap to be in fact: “what was wrong with your blood?” This was in opposition with what had been the case before: what you had done wrong.

This process transformed blood from being regarded as a religious and religion-mediated entity into one under the control and scrutiny of the gathering primacy of biomedicine; the lay beliefs and religious connotations were under pressure from scientific proof and experiment. Evidence that blood underwent a significant societal understanding can be seen in the new adjectival and verbal power attached to it at this time. The miasma theory gave rise to new ideas about blood being a vector for disease and danger that was “blood-borne” rather than as emblematic of purity. This idea was very powerful in changing the power base as to who actually controlled blood-related danger and contagion. Accounts of the corrupting of the blood from external forces exist in the literature, e.g. l’Estoile (1958), whose work examining data from 1609 described the air to be both “corrupt and malignant” (cited in Curren and Stacey, 1988:78). The environment, both natural and manmade, became a new source of illness causation. Combinations of heat, humidity and miasmatic air from the ground contributed to the new metaphysical as well as biomedical causation of illness. The miasma theory bridged the gap between post-Harveyian knowledge base and that which followed. Miasma was the dust or circulating air which was found in newly urbanised areas.

The concept of contagion as a result of proximity to other sufferers and the rise of secularisation placed blood under the scrutiny of both the public and the medical profession. Ideas that link or blame the environment and its link to blood persist today.

Examples of popular sayings include: “feel it in my blood” – i.e. catching a chill from the environment (Helman, 1985). The emergence of the germ theory further consolidated blood as a public related fluid, because the new medical practices such as the development of microscopes could examine the blood itself, rather than the body, for germs. The link between bodily behaviour and badness was threatened and illness became, under the paradigm of the germ theory, pathogenic, as it has become known following the discovery of microbes. As a further extension of rationalisation, the public were asked to believe, rather than their moral behaviour being the cause of illness or misfortune, that the invasion of their body and specifically blood by these microscopic organisms was the cause.

Germ theory was an important extension of the relocation of illness causation to the body rather than the mind or morals, and further this relates to blood as a target of power via its relationship to the body, to biomedicine and an increasing population as well as population-level interest in blood.

A key development within this theory is that disease was a spontaneous event, and that disease was not in any way linked to the individual bodily make-up or behaviour. Moreover, within this theory micro-organisms situated within the blood were regarded as being more dangerous than those found anywhere else in the body – for example, the skin.

The emergence of germ theory further consolidated blood as a fluid that medical practice could examine. Germ theory, as well as the empiricism of Harvey, relate well to this analogy of blood as an increasing target of power by blood’s relationship both to the body and to biomedicine. The change was that blood itself was a host for germs.

Inoculation is another development that added to the whole aspect of medical developments, whose technology and understanding of how the body worked aided further development in the transfusing and bloodletting developments (Starr, 2003:30). The work of Louis Pasteur was a further phase in the processes, which created the link between blood and science, thus crystallising the primacy of science-based medicine. Germ theory and the concomitant practices such as case examination, close bodily observations and germ theory-based pathology eclipsed and saw the decline of bloodletting as the prime medicinal or therapeutic use for blood. Blood was still the focus of developing science-based medicine, but it was to be used in transfusing it into, and not letting it out from, the body.

## **2.8 Transfusion: Professional harnessing of the gift**

Further developments in the blood's relocation as a medical tool were occurring at regular intervals as blood became the location for further scientific discovery. Many experiments in a new process called transfusion were rife; for example, using animals' blood in the case of Jean Batiste Denis in 1667 (Titmuss, 1997:63). This failed and the doctor was charged with murder, which caused public concern, and animal to human transfusion finally was made illegal by the Pope in 1678. This intervention stalled the process of human-to-human transfusion for many years until the contribution of James Blundell in 1818. His invention of apparatus for transfusing blood, as well as suggesting that only human-to-human blood transfusion would be morally and actually correct, was vital in the professional harnessing of the blood and its newly emerging biomedical power. This is because the success which followed Blundell's method and rationale for



transfusion created a clear understanding that transfusion was a specific medical procedure, and was not, according to Winner (2007:39), done to change personality or humoral imbalance, but rather only to replace blood loss in childbirth. Blood was further medicalised by linking blood transfusion to the profession of medicine alone. This was achieved by developing methods and constraints concerning only human-to-human transfusion as acceptable. Blundell was being supported by the professions to make it compulsory for any blood transfusions to be only managed by medical doctors, thus imprinting on the new collective consciousness that blood, its transfusion and monitoring, was under the sole control of biomedical doctors alone.

## **2.9 Grouping and clumping blood groups and making blood last longer**

By 1900, a further development in the journey that blood has travelled in its dislocation from the old ways of understanding it can be illustrated by interpreting the discovery of blood groups. Karl Landsteiner, an Austrian doctor, in 1901 solved the fundamental problem of why so many blood transfusions failed despite the process being fairly simple. He identified the processes of agglutination and the blood group properties of blood. Landsteiner's work was as revolutionary as Harvey's, but in a different way. His work changed the fundamental medical rather than lay understanding of blood, thus removing it from the auspices of the ordinary physician and remaining pluralistic practitioners. The prevailing understanding prior to Landsteiner was that all blood was the same in composition. Thus, giving blood via transfusion was concerned with

replacing blood under this assumption, and therefore mortality associated with “transfusions” was very high despite Blundell’s contributions of safe equipment.

Doctors had witnessed the clumping or clotting of blood once outside of the body, and various substances were employed to stop this “clumping” occurring. Therefore, rather than blood being a “standard” bodily component that could be “transferred” from one person to another, Landsteiner hypothesised that there were in fact individual differences in blood’s make up. He proved that in fact human blood was not always compatible, i.e. that there were in effect different bloods. His experiments which revealed clumping of incompatible cells won him the Nobel Prize (1930). Thus blood returned to being conceptualised as an individually dynamic entity which needed careful medicated testing to ensure safe transfusion. Landsteiner proved this theory and classified these differences in the form of blood groups. The scientific discovery of differing blood “types” reconfirmed the individual nature of blood. Moreover, blood management was successfully relocated from the domestic and bedside domain to the laboratory or clinic.

Between 1914 and 1918 a further important discovery occurred which served to consolidate the new power found in transfusion by medicine. This was the discovery that a chemical liquid called sodium citrate could be added to the donated blood to do very significant things to it, which gave doctors further power. The effects of sodium citrate was to stop blood clotting, and therefore allow the donated blood to be stored for future rather than immediate use. This was significant, because it gave doctors the power to plan where, for whom and when to use the blood.

## **2.10 Antigens and transfusion: Rhesus disease**

The chapter so far has presented a chronicle of blood transfusion; this section examines and theorises what happened next in the history of blood, and how it became a commodity or “service” to be managed, distributed and shared. The relationship of blood to society at population level via the emergence of the fledgling blood service is described here, as it is essential to understand which social, historical and technological factors harnessed blood to the developing welfare state and the biomedical hegemony, and associations with public altruism.

Further medical developments in blood transfusion science conferred life-giving, rather than life-saving qualities on human blood. By this I mean that rather than as well as doctors saving lives, they could give life to babies who would never have been born otherwise. By 1930 the identification of the Rhesus factor confirmed the status of blood as a multifaceted fluid which could, only under the auspices of medicine, confer the gift of life to others. The effective removal of one of the biggest child-killers of the time known as “Haemolytic disease of the newborn” crystallised the power of medicine as the new “truth”.

The scientific examination of blood and its subsequent medicalisation created a paradox. On the one hand blood was presented to the public as a highly individual and unique liquid with blood grouping and rhesus factors, and on the other a fluid about to be organised as a collective fluid harvested and redistributed for the good of others.

The discovery of technology to fractionate or breakdown whole blood into plasma and what the history page of the NHSBT (2010) website terms “blood products” allowed

donated blood to be collected for a new use, that of therapeutic medicine, in the form of gamma globulin, for example, to treat deficiencies in patients and importantly those patients who had blood clotting deficits such as haemophiliacs. Blood was, it seemed, unstoppable in its use to humans outside of the body.<sup>2</sup>

The timing of these events proximal to the First World War tested the new knowledge about blood and its relationship both to the body and the body politics is interesting. Following successful military and medical handling of blood in the Second World War, the practice of blood donation became global. The development of plastic bagging of blood in 1953 was an important phase as it extended the longevity, safety and mobility of blood as a transportable social fluid and thus extended the scope of medical power.

The actual history is well documented in the archives of the Blood Service (Learoyd, 2006), so I want to select a few key dates and events in order to reflect their meaning and impact through an anthropological lens.

There are two key events which are pivotal to the contemporary understanding of the NHSBT, related to the inception of the Service. The first is the decision in 1921 by some members of the British Red Cross charity, under the direction of Percy Lane Oliver, to provide previously donated blood at short notice at King's College Hospital. This was aided by the technological developments in refrigeration, and situated the location of blood donation within the hospital setting. The action by the members of the charity established two important concepts: firstly, the type of people who gave blood

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<sup>2</sup> [www.bloodbook.com/trans-history.html](http://www.bloodbook.com/trans-history.html)

could be trusted by default of their being involved in charitable work, and secondly, the donation was given voluntarily and for no reward. These criteria are in evidence today, with many of the respondents saying that they give because someone has to, not everyone can, and it is a form of charity – giving your good blood away to those who need it. This is a key link to the connotations of charitable citizenship being related to blood donation.

The second event is the subsequent establishment of the first UK blood bank and the establishing of local and regional centres thereafter, which significantly recruited civilians to donate rather than those in the military services. This established the onus for blood donating onto the general public, which has persisted until today. By 1946 The NBS was launched predating the actual NHS. The service was developed along the lines of these two events, i.e. the blood came from voluntary un-rewarded donors from a suitable background.

Events from a technological perspective which enabled the fledgling system to become very effective were just as valuable as the welfare and social events. The development of plastic bagging and testing for an ever-increasing range of newly discovered viruses allowed a further aspect of the contemporary blood service to emerge. The crisis of infected blood is dealt with later in the thesis in the chapters on gift and deferment; however, it is useful to note here that testing for HIV began only in 1986, and later on in 1996 the Service tested for hepatitis C. The infecting of the blood supply by these new viruses was as damaging to blood transfusion as the failed transfusions of the past. The moral panics about this were powerful and have changed not only the surveillance

expected of actual blood by the NBS, but also the ways in which donors were reviewed. This aspect is dealt with in Chapter 5.

The newly formed National Health Service Blood and Transplant (NHSBT) was formed in 2005 and included a division dealing with what it calls Bio Products Laboratory (BPL), as well as blood and organ donation and transplants. It is the “bio product” aspect that illustrates the new way in which extracorporeal blood has become an entity of its own, and, more specifically, parts of blood has become entities of their own. This has ramifications for how blood is perceived in relation to the Self.

Reading the webpage of the BPL, it is possible to forget that they are talking about a part of a human body. Instead, the whole language is of marketing a successful product; for example: “The BPL is committed to research and development in the twenty-first century to maintain a key position in a constantly changing market.”<sup>3</sup>

The philosophy of the division is to provide a continuous supply of high-quality plasma-derived products, both in the UK and abroad. The products are divided into three groups: human coagulation factors, human immunoglobulin and human albumin solutions. According to the website, it also can produce a “small volume of products for a niche market”.

The BPL is the end product of what started with the success of blood transfusion. Being able to synthesise man-made blood replacement components and create a market for

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<sup>3</sup> [www.bpl.co.uk/about-bpl](http://www.bpl.co.uk/about-bpl)

them has created consumerism and an economy of blood, in the same way as there is an organ market. The blood products which are available are so far-removed from the donation that donors would be forgiven for not feeling any relationship with the product they give and the one the BPL sells or distributes. This notion is explored in Chapter 8 Blood Donation, the Body and the Self.

## **2.11 Conclusion**

The reviewing of historical events facilitates understanding of blood donation in contemporary time and place and provides a starting point to challenge the early roots of perceived altruism. It has also provided a rationale for examining the changes in an ethnographic study of blood donation in the UK, and demonstrated that culture and scientific knowledge have changed and evolved in relation to our understandings of blood, in positive as well as potentially negative ways. It was important in this chapter, for the context of the research that follows, to retrace the journey which blood has made from being a mythical substance related to God and goodness to its new incarnation of being a literal life-giving force, with connotations of risk, relatedness and a new sort of goodness, citizenship.

The chapter also has resonance for how there are still differences in the lay and professional concepts of what constitutes official knowledge concerning blood. It has also reiterated the powerful hold biomedicine had and continues to have in the realm of blood and blood products.

What has been illustrated is that blood, not the rest of the physical body, was the target of professional power as the enlightened thought elided the old ways of thinking about

blood, and also how the developments in blood management in the past were just as important as blood management systems are in the present. The chapter also locates blood transfusion services in the context of altruism. The data-inducted chapters relate to the contents of this chapter as they are concerned with public management of blood and its donation in the areas of risk, deviance and exclusion, and biomedical control of the gift.



## **Chapter 3 Literature Review**

### **3.1 Introduction**

The literature review serves to contextualise the project in relation to the literature pertaining to the research question and highlight the relevance of literature reviewed. This serves to relate the research questions to the history of blood transfusion, altruism, sociology of the body, biomedicine and the literature on both sociology of risk and citizenship and the gift relationship itself. The chapter is divided into subsections which relate the literature to the aims and objectives of the thesis. The initial section reviews the literature on the gift and the work of Richard Titmuss and other theorists on altruistic exchange. The following sections examine literature pertaining to risk, citizenship and deferment. The review then extends into literature related to the biomedicalisation of blood, the body and the self. A further section examines blood in an anthropological context. The literature review also serves to debate the methodological approach utilised in the first instance.

It is important to include a small discussion here about the epistemology of this type of approach to understand its full value to my thesis and how it has added to knowledge about blood and blood donation, and more especially the quality of the data gathered. I also went back to the work of Malinowski (1922) and his extended ethnographic approach. The qualitative nature of research by participant observation optimises the subject to be researched through a thick descriptive lens (Geertz, 1993 ch.1), providing

insight into private feelings, thoughts and actions of the donors and others involved in the study, which is the overarching aim of this thesis.

Within this epistemological paradigm, the concept of what constitutes knowledge is problematic as observation largely depends upon perception (Marsh, 2002). Making sense of data collated via the qualitative and interpretative approach is dependent upon the individual; it is what Weiner (1992:23) asserts is akin to making up of the “culture” of the fieldwork. This approach, therefore, necessarily reflects on the author in the field and the difficulties and experiences from that time which produced the text from the gathered data, thus creating a picture of the culture of “giving blood” in the UK nowadays.

A further benefit of using an interpretive approach is that the primary social actor and the embodied experience of giving blood can be focused upon. The embodied experience of blood donation is demonstrated by the physical presentation of the donor. Quantitative researching, which focuses on, for example, the different blood types, age range of donors and how much blood was collected, is more readily available (Armitage and Connor, 2006; Ferguson and Chandler, 2005; Glynn et al., 2002); however, it is asserted here that such research does not evidence the real story about gifting of blood, because the method employed in quantitative research relies on contact with donors over a short, possibly anonymous and remote, period of time.

At the start of my literature search I went back to the seminal anthropologists to see if there was any aspect that would have any resonance for this project. Malinowski (1916) demonstrated that to reveal the truths and explanations for social interaction, researchers need to locate themselves in close proximity for a long enough period of time to see

reoccurrence and regularity in meanings, what he termed the “corpus inscriptionum”. Kuper (1997:115) has successfully imported the usefulness of such seminal research for the contemporary researcher by reminding us of the basic principles of this methodology necessary to procure evidence which is *regularly* evidenced from the subject: “the native’s point of view”. The reality of “layers” of reality witnessed by Malinowski was a reminder to me that there would be layers in the action of giving blood and therefore differences between what is said about giving blood and what is observed. The evidence presented here, it is argued, presents the evidence so far of the changing meanings and position of blood and blood giving by default of spending an extended period in the field.

Geertz argued that there is no such thing as a superficial societal practice. He argued, like Goffman (1990), that they act as surrogates for conveying meaning and hierarchy in society (Martin, 1993:273). I would concur with this argument here in that the act of giving blood is not the simple altruism of the past it was considered to be, but, on investigation, it reveals new meaning in contemporary UK society. This is in who gives, why they give, and, more saliently, what they think is the point or benefit to themselves as givers, and also what they think this activity means to them and others.

This can compromise the “findings” as the truth: would another person have seen different ideas embedded within the blood donation than those presented in this thesis? However, in practice, when actually carrying out the research, the data gathered by the qualitative researcher is verified by other means: by the way the body is engaged (Coffey, 1999) and language used by the observed. This acts to triangulate the data.

## 3.2 Review of the literature

The following section reviews anthropological and sociological literature on blood and the related themes that were evident from the literature search, but also it reflects on the themes that emerged out of the early part of the fieldwork. These themes and issues became the core topic of each of the chapters. Both anthropological and sociological literatures are considered, since blood and the body and the gift relationship in the UK come into the purview of both disciplines.

Blood is a common bond between humans. Despite other physiognomic differences (e.g. skin tone, hair and eye colours), blood has the same colour and physiological construction across all ethnic groupings. It also looks the same to the naked eye. Throughout history, blood has been lauded as a vital and precious fluid, ascribed with special importance in many cultures. Our language is littered with the properties of blood such as “life-blood” and “full-blooded”. Blood is at the heart of all social relations and as such the ways in which it is expressed and managed in societies is the embodiment of them. The practice of one person giving their blood for use by another has a ragged history as the processes that led to successful donation and reuse of blood clashed together old and new cultures. At present, only 4% to 5% of the eligible population in the UK donate. Recent advances in medicine and surgery mean that the modern National Health Service (NHS) needs seven thousand units of freshly donated blood each day, and there were over 20 reconfigurations of blood products listed in the 2011 blood component directory which would be available for medical and

pharmacological reuse. This affirms the scope of the need for the blood donors in modern Britain.<sup>4</sup>

Blood has been of interest in anthropology in the past, mainly in relation to its connotations of lineage and kinship structures and rites of passage (Van Gennep, 1960; Knight, 1995; Strathern, 1995; Holy, 1996; Carsten, 2000; 2004). Carsten, in particular, has refreshed the debate about lineage and kinship by problematising what it means to be related in the contemporary world and how understanding the role of bodily fluids such as blood can be seen to represent the heart of relatedness and the expression thereof. The reframing of kinship in the contemporary world has been very relevant to the subsequent debate on how the understandings about kinship as represented by biological ideas can sit happily with the emerging concepts of “social kinship” in the new body part world. Hutchinson (1996 cited in Carsten, 2000:55) examines blood as an exchange medium for the Nuer and as a binding force which keeps the group together. Her study is relevant because it examines the changes brought upon the media for cultural relatedness, which are altered as society is impacted upon by postmodernism. The Nuer consider blood or “riem” to be a most powerful and mysterious substance, capable of dividing and uniting society. So integral to actual life is blood that newborns are called blood for the initial months of life. Riem is in fact a word used for all body fluids, e.g. semen, milk and sweat, arguing therefore that fluids are, as Carsten calls them, the “mutable” source of social energy. Within the Nuer cosmology blood is a cardinal principle of life, passing from person to person, endowing them with social relations,

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<sup>4</sup> [www.blood.co.uk](http://www.blood.co.uk)

and it is within the gift of blood that generation-to-generation authority and respect is transmitted (Carsten, 2000:58). The coming to adulthood for both genders is marked by blood. For women the blood, which comes at the first childbirth, is the rite of passage, and for the males it is the shedding of blood at the ceremony of marking the forehead with horizontal lines as early as the age of six. Other social status relations are symbolised through the use of blood; the brotherhood ceremony, for example, is thought by the sharing of blood to ensure the trueness of the Nuer people. Blood is thought to be the actual carrier of illness, therefore also viewed as a source of vulnerability, pollution and danger in the form of inherent weaknesses for acts such as suicide, adultery and incest. One quote from the research on the Nuer about blood's properties is: "Blood is like a medicine in that it carries all the indirect consequences of other people's actions." Blood for the Nuer, therefore, is concerned with forming social bonds and identities.

Lambert (cited in Carsten, 2000:73), in her work with the indigenous population of Rajasthan in Northern India, revealed some differing, as well as similar, beliefs about blood. In other examples of blood creating cultures of relatedness, this people believe that blood is created through digestion of foods and that blood is a link to patrimonial line. Thus allowing understandings as to why donation of blood to be given to unknown recipients is alien to sections of the modern world. The dual status in which modern blood finds itself is at the intersection between nature and culture. Copeman (2009) has widened the scope of research in relation to blood donation by opening up the area of cross-cultural donation meaning and practices with particular reference to religion in India. He has engaged with the subject of blood donation in an innovative way,

investigating notions of devotion and blessings as the trigger to become and remain blood donors. His work on the role religion plays in the sociality of blood is an aspect which further deepens the complexity of all things to do with blood and donation. The interplay between science and religion is an underexplored avenue in the research area of blood donation in the UK and may go to explain the difficulties the authorities have in recruiting donors from ethnic minority groups. In his introduction Copeman (2009:1) states that:

In India, as elsewhere, the transfusion and donation of blood are far from being purely technical processes restricted to medics concerned with practical medical matters. Rather, they are procedures that transcend their official purposes, and that, in so doing, shed light on multiple aspects of social life.

From this point of view we can argue that, in the UK, blood transfusion and donation at present are regarded only as technical processes.

### **3.2.1 Mauss, Titmuss, gift exchange and altruism**

The anthropological literature pertaining to gift is, it could be argued, romancing the gift relationship, which has further limited current investigation of gift-related phenomena and is limited to the historically and socially embedded treatise of Mauss (1990) whose work centred on the giving relationship in the context of maintaining social relations. In between there seems little actual interpretive analysis since Titmuss (1997) to reveal the discourse from the donors themselves. Gift and gift exchange cycles and systems are a feature of most societies, both for management of material possessions and for the economic organisation of marriage partners and property (Mauss, 1990). Malinowski (1922) argued that gift exchanging was a natural propensity for societies; this is because

the main purpose of gifting in society is to create or reaffirm a social bond between groups, and to create responsibilities between each other and for each other. Weiner (1992:2) examined this inherited lens of normalcy being applied to the reciprocal nature of gift systems and argues that it could be seen as a myth which confers stability on populations undergoing great change such as capitalisation. Within this theory, it is possible to see that the body and its constituent parts in contemporary British society have become a complicated contemporary gift exchange system. Whether donated blood is constructed as a pure gift or an exchange is debated later in the thesis.

Weiner, in retracing Malinowski's steps, has created a further dimension of interpretation of the "gift" relations in society in that she argues that gifts are inalienable from the giver. This notion is explored in depth in later chapters as it is argued that donated blood has developed the status of inalienable, i.e. a gift to whom the giver remains attached to rather than a gift conceived of as being given away for good.

Coleman (2004) examines the "gift" and presents it as a form of charismatic giving, in that the meanings of blood donating are difficult to see clearly. He argues that Mauss (1990) states that the transactions making up human life retain strong elements of interpretation, interpersonal connection and mutual responsibility. This threatens the concept of altruism in relation to blood donation. Further, Coleman (2004) argues that we should review blood donating less as an act of altruism and more as a sort of "covenanted" relationship. This may concur with Mauss' (1990:65) inherent morality of the social market. This concept of covenant is analysed further later in this thesis, arguing that it is the basis of the new gift relationship.



Mauss' (1990) theory has relevance for my ideas about the meaning of "donorism" because of his argument that gift exchange systems give the appearance of being voluntary or spontaneous, but are in fact an obligation for and on behalf of society and the groups therein. In relation to blood, the obligation has become so onerous, especially for rare blood types or tissues, that the expectation of society about the availability of donated parts and blood has risen above the real availability. Further, the impact of scandal and infections related to the blood supply has brought a new importance to the idea that givers give blood for those who cannot. Mauss' theory was useful to reread to allow a reconstruction of the gift relationship between the body and society, and more particularly, the relationship between society and blood donating (Mauss, 1990; Osteen, 2002).

Coleman (2004) argued that in fact the altruistic role is taken by the NHS Blood and Transplant (NHSBT), which can fulfil the reciprocal requirements of a pure gift relationship because of actually witnessing the gift being given. This is because the role of the NHSBT is that it operates as mediator between society, donors and recipients by recruiting only those who can give and thanking them on the recipients' part. Therefore, the process of donation is now dependent on the truth finding capability of the NHSBT rather than the truthfulness of the giver.

Frow (1997:110) has provided a further perspective on the notion of the gift, which is that gifts may be construed as more of a loan, with the gift continuing to form part of the giver even when it is passed through several recipients. Donated blood does pass through several recipients (Valentine, 2005:114). Valentine has investigated the giving behaviour of Australians in his paper. He exhorts that altruism has been codified by the

current background issues such as deferment, and that the giving behaviour is now motivated by moral obligations to give correctly. However, in his study he asked whether unpaid voluntary blood donation was in effect charity, and he had responses that construed blood donation as a different sort of giving to money, for example. For example, one of his respondents said anyone can give money but giving blood is somehow a message to the public that the donor cares. This illustrates that blood donation is not a one way act anymore, in that donors want the public to know that they care about others.

At the outset blood donation had seemed to be summed up by the seminal study of Titmuss (1997), which had located blood donation firmly in the altruistic paradigm and had not been reflected through the lens of medical anthropology and sociology. It seemed germane to re-explore the issues related to blood donation and the gift relationship that Titmuss had been exposed to. These are largely issues to do with the pace and scope of medical science and the impact on societies of modernity. This thesis examines these areas in later chapters to examine what these changes have meant to the blood supply, who supplies it and what is done with the blood, and compares the findings to those of Titmuss.

Titmuss could not have expected his book *The Gift Relationship* (1997) to be the seminal and overarching source of reference about gifting behaviour in the years since he wrote it. It is a piece of literature of its time and as a result of the many societal, biomedical and technical changes it may well be approaching the end of its theoretical relevance in some respects. Recent researcher has re-examined the position encased within *The Gift Relationship* (Busby, 2004; 2010) in relation to the impact of donations

for genetic research. Some of the intricacies of his analysis of the relations between the state and blood donors have become clouded over time as the assumptions of altruism took hold, making further investigation seemingly futile to other researchers.

In his seminal work about giving blood and social policy, Titmuss explored who donated blood and why, trying to make some interpretations for society as the post-war transfusion service became countrywide. He described some feelings of obligation in those donors who answered the questionnaire. Many felt that giving blood was a social duty, especially with regard to those who had rare blood types. Other respondents had continued donating blood as a result of social conscience during the Second World War (Titmuss, 1997:292–296). Titmuss argues that blood is woven into the fabric of every culture, being both a metaphorical and an actual potion that rejuvenates societies, by and with which social ritual and ceremony is measured. Changes in society across time in the UK contradict this, as blood donation is largely un-ceremonial in its process, except in exceptional circumstances such as the 2001 and 2007 terrorist attacks or natural disasters, when indeed the action of blood donation rejuvenates social connectedness (Waldby and Mitchell, 2007:2).

Pinker (2006) confirms the pertinence of Titmuss' work to the contemporary debate in his work concerning the possibility that behaving in an altruistic way is pro-social. Being free to give blood is not as simple a relationship with society as it appears. Altruism is only possible, he argues, when needs are met in society through collectivist values prevailing in the social market. The actual type of altruism that currently prevails, therefore, is a form of conditional altruism. Titmuss predicted that the alienation of the giver from the destination of the product would be problematic in

relation to blood donation (Titmuss, 1997:242). Pinker argues that this alienation is a regulating mechanism that acts to control unfettered altruism and in turn control the possible infiltration of unsafe blood. The danger of unfettered altruism is that not everyone can be involved in the giving of blood. In popular discourse emanating from Titmuss (1997), the concept of blood donation is built on the understanding that blood is so desperately needed that anyone and everyone should give and be allowed to give, thus not being allowed to express this right leads to tensions between the voluntary donor and the blood service.

Titmuss (1997:124), in reference to blood donation and the gift exchange systems, argued that the different forms and functions of giving serve to embody moral, social and legal ideas. Simmel (1950) argued that society exists where a number of individuals enter into interaction. This interaction is purposeful in achieving desired aims for the mutual benefit of that society, and they create subsequent unity or socialisation therein. Therefore unity is derived from the sum of interactions. Simmel's views on exchange are pertinent to my research. His views on exchange as being the purest and most obvious form of human interaction is interesting, especially the argument that exchange must be reciprocal, and that a characteristic of pure exchange must be that the sum of value to each party must be greater afterwards than before. In the case of donated blood, therefore, the pooling and reconstitution of blood into its products would constitute pure exchange rather than the donated blood itself. This is because in contemporary society blood has more value when out of the body than in it. Coleman (2004:342) argued that such action would reduce the property of the gift. There are some echoes of this in accounts of respondents who highlight the lack of specialness of their gift. Berking

(1999:32) argues that the giving of gifts binds everything together, gifts and gifting being representative of social synthesis which irrevocably unifies economics, power and interestingly morality. Mauss (1990:5) in *The Gift* states that the gifts are, in the final analysis, even if given in the guise of voluntary politeness, in fact strictly compulsory on pain of private or public warfare. Mauss further tells the observer about the group relationships, in particular the role of gifting in creating and maintaining relationship between groups.

Titmuss (1997:127) tabulates his thoughts about whether donating blood constitutes a gift in the light of these statements and what a gift entails. Some of the list remains relevant to today, but in relation to the criteria “no givers require or wish for corresponding gifts in return”, it is argued in this thesis in Chapter 7, “Giving to Get Back: From Altruism to Covenant”, that in fact this has altered. Further criteria as listed by Titmuss also became relevant to my study; the criteria whereby “only certain groups in the population are allowed to give: the selection of those who can is determined nowadays on rational and not cultural rules by external arbiters” is under challenge. This aspect is discussed in Chapter 6, “Deferment and Citizenship: Too Risky to Give”, in relation to current issues on deferment.

A further issue central to the value of donated blood and the altruistic paradigm is whether the donation is voluntary or paid for. Erwin (2006), in recent anthropological analysis of blood donating in China, concentrated on analysing the reorganisation from paid to voluntary donation of blood in China and how this had an impact on the cultural meanings of gift exchange, which are embedded in contemporary Chinese society. Simpson (2004) similarly explores this conversion from paid to voluntary donation in

Sri Lanka. Both conclude that a free gift becomes problematic, highlighting that the body yields gifts that are deeply problematic for societies who have unclear rules about gifting. The lack of clarity of rules and uses on blood can give rise to disorder and lack of contribution to society. Periodically, here in the UK, a similar lack of clarity over the uses of donated body parts and blood have caused concern. The present methods and organisation of blood giving in the UK have not led to such problems for blood recipients, despite gathering evidence that following donation, it (blood) becomes a product very different in capacity and agency than the state in which it was given (Copeman, 2005). This is due to the unambiguous voluntary nature of giving. Sahlins (1972:160) stated, prophetically if we relate it to current controversies over blood donation, for example, that “one man’s gift should not be another man’s capital”. This argument is particularly pertinent to the themes I have identified in this thesis, as in relation to blood this is precisely what has occurred. The innocuous donation of blood has turned into an unrecognisable product, and the convention of a voluntary supply of blood does not mean that there is no selling of blood here in the UK.<sup>5</sup>

Titmuss (1997:124) postulated that a change in name would better articulate the relationship between society and blood donors. He argued that a more neutral title of “supplier” would be better to describe the actions of those who “give blood”. This may be more accurate now than then, as Chapter 7 of this thesis, “Giving to Get Back: From Altruism to Covenant”, argues that in effect the greater motivation for many is that they

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<sup>5</sup> [www.nhsbt.nhs.uk/about/strategy/nhsbt\\_strategic\\_plan\\_2010\\_13.pdf](http://www.nhsbt.nhs.uk/about/strategy/nhsbt_strategic_plan_2010_13.pdf)

“give to get back” rather than only to feel good. Therefore the giving of blood is a conditional societal interaction rather than an unfettered altruistic event.

A further theoretical perspective on altruism relevant to review in relation to blood donating is Derrida’s (1992) phenomenology of the gift. Derrida’s work on the gift is related to these changes in relation to the gift being seen to be received and how the NHS as collector of the gift operates in the contemporary society. Copeman (2005) examines the gift in relation to Derrida’s four critical conditions required of a true gift. The initial component, which may declare blood donation as not being a free gift, is that there is no discernible reciprocity evident in the donor system at present. The gift is vicarious in order for the cycle to repeat itself. If this was not the case, the gift would not take place, as in true gifting the giver must always be repaid and self-praise or obligation must not be allowed to surface (Mauss, 1990; Malinowski, 1922). Knowledge that the gift has been received is an essential part of the cycle of giving. In blood donation once again the story of the recipients is given vicariously. This happens through the media or in special publications or magazines, for example the recent campaigns saying thank you to donors rather than appealing to donors (NBS, 2009). Copeman (2005:468) had information concerning this from an informant who said that giving information about recipients to donors was about striking a balance between not enough information and too much. This is more specifically related to the rarity of the gift (e.g. donor-specific platelets). Media campaigns and adverts evidence vicarious recognition of the gift, as the adverts ensure that thanks are seen to be offered for the gift, thus locking the give back into the exchange cycle.

Blood donation today is contrary to points B and C of Derrida's (1992) classification, therefore, and the cycle of gifting is under the control of the blood collection system, the NHSBT, as opposed to the direct giver. A further aspect of blood donation that is becoming problematised is that the lost blood is always replaceable due to the inherent capacity of the body to remake blood, thus making it appear that nothing was actually given in the first place.

The work of Durkheim can successfully be incorporated to this thesis in a variety of ways in relation to challenging the altruistic underpinning of the blood donation relationship. Durkheim regarded blood as a fluid which society could both regulate and become regulated by (Durkheim, 1897; 1997). This is because, he argued, for any society to exist it must be organised through bodies and the body is the location for symbolism about society. The body exterior according to Durkheim (1912; 1995:217 cited in Schilling, 2001) is the significant location, therefore, for examining social order and cohesiveness. Moreover, bodily congregation becomes a stimulant and generates an energy which he termed "collective effervescence". This is a powerful social force which results in facilitating behaviour change as group behaviours become based on collective moral and shared understandings. This behaviour is seen in gatherings such as blood donation sessions, where all the donors act as one, resulting in acceptance of exclusion and deferment. The issues relating to deferment or refusal to give the gift may be interpreted in this way. Durkheim argued that the symbols which create *collective effervescence* must possess both cognitive and emotional connections, leading to a transfer or change in behaviour of individuals; also, it is through this trajectory that the groups' identity is forged. This has resonance for the feelings and behaviours seen in



modern blood donation settings and in the press. Durkheim's notion of social holism is important when reconsidering the scope of altruism. Durkheim linked altruism to the morality inherent in those societies displaying social holism. The changes in relation to altruism within contemporary societies therefore may be concerned with a concurrent change in the moral collectivism (Dubeski, 2001:4).

### **3.2.2 Risk society and the changing cultural symbolism of blood**

Blood, historically, has been symbolic of the ordering of societies (Douglas, 1996). It has a role in creating and maintaining blood ties and lineage with social harmony, both resting and falling on blood, symbolically "managing societies" via economic and filial inheritance (Foucault, 1977; Malinowski, 1922; Kuper, 1997). Blood has always had both a functional and symbolic role in societies, implying connectedness and linkage. Many rituals and ceremonies use blood to manage rites of passage in cultures, for example puberty, as well as the management of misfortune and illness.

As previously cited by Douglas (1996), the meanings attached to blood can be said to have become more complex than simply representing both purity and pollution symbols. Other categories have emerged which are representative of the modern world, for example. The idea of purity versus pollution has become more complex to include other notions and connotations representative in the contemporary world. For example, blood is now symbolic of the power of the law and culpability (e.g. like DNA) with blood being forensically examinable. Donated blood is pure, provided it is donated within the "proper" surroundings. In India, for example, where the blood service is mediated via the context of religion and blessings, donation centres can be situated anywhere a tent can be set up (Copeman, 2009) to maximise the donation from as many

people as possible. In the UK such camps may be only tolerable in extreme circumstances such as the terrorist attacks in 2001 and 2007. This is because the context of UK donation is mediated through the clinical lens as blood is medicalised.

Symbols and imagery of blood depict life forces, religious control and danger, and blood is the target of taboo. The function of taboo is to create order, which draws attention to issues of sacred and profane, purity and pollution. Blood's symbolism is also transformed by what kind of blood it is, who has touched it and how it is utilised. As a result blood can be in two places in society: both in place and out of place; being out of place creates liminality and disorder (V Turner, 1967; 1974; Van Gennep, 1960). Skultans (1970 cited in Buckley and Gottlieb, 1988:137) examined menstrual blood symbolism and found that women afforded wide and differing symbolism attached to their menses in relation to how polluted it made them feel. Some donors in my study also described feelings of pollution in their blood if they were not "bled" regularly as a result of giving blood.

Blood that is "in place" is safe and manageable, being linked to purity. Blood being seen "out of place" is defiling, polluting (Douglas, 1996:216). If we take the example of donated blood, we can see the corollary between the blood donated and taken from a body which is cleansing or life giving, and the blood shed in uncontrolled circumstances; e.g. a nose bleed or menstrual blood are contaminating (B Turner, 2003). This has resonance for the difficulties ensuing with regards to "bad" blood donors and donations of what turns out to be infected blood.

The strict ritual symbolism which surrounds blood donation exists in society for a reason. The processes that surround the bleeding of donors exist to provide a symbolic

as well as actual framework for the separation of blood from one body to another, that being the NHS. The quasi hospital environs also serve to augment the safety of both the giver and the receiver. The current public interest in blood safety in the UK has increased due to the emergence of blood-related scandal and moral panic (Cohen, 1973; Garland, 2008; Klugman, 2010). Moral panics in relation to blood supply failures have been successful in adding to the social control mechanisms which manage blood, the most recent of which resulted in the Archer Report 2008.

Cohen (2002) resets the moral panic clock in the third edition of the classic text on moral panic theory, where in the introduction it is argued that the objects of modern moral panic can be warning signs of deeper conditions related to the object of the panic (p.iii). My fieldwork reflects what I refer to as micro-moral panics rather than full-blown cycles. Moral panics over the course of this study were linked to seasonal shortages of donors as well as special types of blood, and contamination of blood supply from risky groups/individuals. Risk was directly related to the size of the donor pool from which the blood or plasma was collected and to the lifestyles of the communities from which donors were drawn according to the Archer Report (2008:54).

Thus, a major aspect of modern blood donation, which separates it from the preceding paradigm of blood as a gift, is that of being “deferred”. Deferred is a status conferred on an existing donor by the collecting authority as a result of the donor presenting to give blood with a changed status or lifestyle. This means presenting with a risk factor which can be related to travel, recent illness or change of lifestyle or behaviour. Deferment in relation to blood donation means that your blood is excluded from being donated. The

NHSBT highlight in their website, in 2010, that the first reason for deferment is the health of the potential donor.

Some groups, such as male homosexuals and sufferers of viral illnesses such as Myalgic Encephalitis, are unhappy with the power of the NHSBT to taint groups of the population by excluding them from donating, an act that has been articulated as being a civic duty.<sup>6</sup> The NHSBT itself codes those deferred into three broad categories; those who are at risk from giving, those whose gift poses a risk to recipients and those whose gift poses a risk to the blood supply itself. This categorisation takes direction from a government committee, the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO).<sup>7</sup> The deferment criteria at the time of submission of this thesis were wide ranging from the mundane, such as having recently donated or suffering from a mild cough, to more sinister reasons, such as having worked as a prostitute, injected drugs or had gay sexual relationships with men. The criteria are further considered in Chapter 6 of this thesis, “Deferment and Citizenship: Too Risky to Give”, examining the concept and scope of deferment. O’Neill (2003) examines the impact of deferment of donors against the backdrop of politicisation of UK blood. She reviews the impact of deferment on the inherent trust between society and its blood. She also reflects on globalisation in relation to the long-held notion that blood donation is an act of community. The growing number of “would-be” donors due to deferment is related to this concept of blood as risk. This reaction to the reinvasion of blood by viruses and

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<sup>6</sup> [www.guardian.co.uk/commentisfree/2008/dec/01/gay-blood-donors](http://www.guardian.co.uk/commentisfree/2008/dec/01/gay-blood-donors)

<sup>7</sup> [https://secure.blood.co.uk/c11\\_cant.asp](https://secure.blood.co.uk/c11_cant.asp)

bacteria is a pivotal moment in the recent history of blood; it relocated blood at the centre of the Beck's "risk society" (1994) and politicised the activity of "giving".

As will be discussed later in Chapters 5, "From Gift to Risk: Challenging the Orthodoxy of Altruism", and 6, "Deferment and Citizenship: Too Risky to Give". Blood has, it could be argued, become the very symbol of the risk society due to its connotations of contamination and infection. Risk theory is therefore highly pertinent for inclusion in the thesis. The study was carried out against a backdrop of public investigations into the contamination of donated blood (Archer Report, 2008). The respondents' interest in risk and blood was interesting in that sometimes there was no mention of risk and danger and sometimes there was. Perhaps the most interesting aspect of risk was the concept of deferment. A formal definition of the concept of deferment is the status or terminology used given to those who are barred from donation. Being deferred seems to be a crisis for the truly altruistic would-be donor. Accounts of how this affects them are described in Chapter 6, "Deferment and Citizenship: Too Risky to Give".

The following statement is from the NHSBT (2010) about the rationale for screening out bad donors:

Blood safety starts with the selection of donors before they give blood. By excluding groups known to present a particularly high risk of blood-borne viruses, we are already reducing the risk of infected blood entering the blood supply.

The key phrase here is that blood safety starts before the donors even get to give blood. This is in contrast to the preceding "giving the gift of life" philosophy, whereby the understanding was that only safe people would put themselves forward as potential donors in the first place. As such, it causes tensions between feelings of altruism and

having the gift turned down. Deferment issues concerning homosexual men are being problematised with pressure groups such as Bloodban.<sup>8</sup> Bloodban is a pressure group whose purpose is aimed at overturning the existing ban on men who have had sex with men from donating their blood. The group point out that other groups are just as risky as, or more risky than, this group, which has been singled out for a lifetime ban.

Deferring, therefore, imposes a new self on the donor; that of not being good enough to donate. It therefore challenges the concepts both of mutual trust and altruism in relation to voluntary donation. This is because the ever-increasing number of deferment criteria acts as a form of exclusion.

The changes in surveillance and monitoring of blood can be argued to have politicised it. O'Neill (2003) examines beliefs about the "vital fluid". Against the backdrop of politicisation of blood, she reviews the impact of deferment on the inherent trust between society and its blood.

The growing numbers of would-be donors due to deferment criteria is a cause for concern for donors, who worry if they will be removed from their duty, and creates tensions in society between blood safety and not enough blood supply.

Klugman (2010), in investigating blood and its metaphors, highlights the growing link between deferment and risk management, and links the language and tone of recent marketing campaigns in the blood donation industry as creating a new metaphor about

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<sup>8</sup> [www.bloodban.co.uk](http://www.bloodban.co.uk)

blood giving. He argues that although blood donating is not a human right, new campaigns relate the eligibility to donate as becoming indicative of being morally virtuous. The American Red Cross (2009) states that despite blood being needed every two minutes, only 5% of the American population is eligible and healthy enough to donate. The problematisation of this growing relationship between virtuousness and eligibility to become, and remain, a blood donor is one which the UK blood donors may understand.

Healy (1999) traces the emergence of HIV in the US and discusses the concept of “uncertainty” it brought to the blood system. Healy reflects first on Titmuss’ (1997) argument that by maintaining blood donation as voluntary, the risk from what Titmuss called “skid row” donors would not occur. By allowing pure donation and not the market as the only social mechanism controlling blood donation the bonds of the community would be strengthened. Healy argues that Titmuss’ view was too simplistic. He further argues that both the market and altruism are embedded in the social structure and culture. In contrast to Titmuss, Healy argues that linking blood to market forces would have a positive, not negative, effect on the quality of blood received in view of the prevailing invasion of blood by viruses such as HIV. This is because the donors who query their own suitability stay away.

In 2008, the Health Protection Agency (HPA) published *Safe Supplies: Testing the Nation*. This report was designed to present the findings and activities of the donor surveillance systems that have been embedded in the NHSBT. It argues that the NHSBT is responsible for providing a safe and reliable supply of blood. Fundamental to this is the appropriate selection and surveillance of donors. In 2008, 2.5 million donors were

tested and 313 were positive for infection, with hepatitis B infection being the most prevalent. New donors were more likely to be tested positive (259 out of 313). This is largely due to the donor not understanding the deferral criteria and failure to acknowledge previous behaviours or events which would defer them from donation (HPA, 2008).<sup>9</sup>

Healy (1999; 2006) raises the question of whether “good gifts” mean risk-free blood. The blood industry suffered serial contamination and crises concerning unethical practices as it sought to satisfy the newly emergent blood markets in the 1980s rather than serving the interests of the producers and recipients of blood. As a result, the safe and reliable reputation of the NHSBT and the donors was damaged by the contamination of the blood supply with HIV and other viral infections, together with evidence of misuse of blood and blood derivatives (Starr, 2002).

This has led to what I would call a reclassification of blood and blood management systems in popular discourse as blood has become a possible source of risk and a polluter rather than a solely clean and altruistic entity, which was how it was portrayed in the post World War II solidarity as highlighted by Titmuss (1997).

Healy further argues that in hindsight there is no doubt that there is a right as well as a wrong way to react to the sudden arrival on the blood donation scenario of viral agents, which created the new self-managed system I describe in this thesis. He postulates that the overreaction to managing the risk to the blood supply was political rather than

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<sup>9</sup> [www.hpa.org.uk/web/HPAwebFile/HPAweb\\_C/1254510606634](http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1254510606634)



arrived at through risk assessment (Healy, 2006:107). O'Neill (2003) has also reflected on the impact of these failures in that the decision was taken to permanently exclude people in the US who had lived in Britain during the time of a further threat to the blood supply during the period of mad cow disease. She highlighted that as well as keeping the blood supply safe, this new risk-based trajectory should not deter donors from assuming that their gift was not wanted or needed.

### **3.2.3 Blood as cultural symbol**

Postulating the idea that gift has become risk, and referring to the seminal work of Douglas (1996), I would like to show that blood donated by the public has been “recoded”, and in certain situations what was once a safe beneficent gift has become a polluted risk, i.e. out of place and therefore liminal. Douglas argues that societies innately “code” all aspects of their culture according to the pollution quotient it carries. The code is at once functional and symbolic.

Blood management, according to Douglas (2002), especially needs to follow pre-identified social rules as to what blood can be used for whom and by whom, who can give it and who gets it. Blood management systems need to be evident in a functional way to sit happily in societies. Each society can use blood in a specific way. Perhaps the technological changes and capacity that surround blood at the present time have challenged the old ways of seeing blood, and it is in this way that new rules about it, who gives it, who receives it and what happens to it, need re-clarification. Chapter 5 will explore these issues, relating my fieldwork to recent events.

Both the body and blood carry social meaning and symbolism across many cultures and are, according to Douglas, “natural symbols” (Douglas, 2002; V Turner, 1974). Douglas (2002) introduced the important concept of a two-way relationship between the body and the society in which it lives. Society constructs and controls the “body” within it and communicates its meaning via the use of what she called “natural symbols”. The use of metaphors, special dress, taboos, etc. attached to all areas and functions of the body have their place in this argument.

Douglas (2002:73) argues that perception of symbols and their interpretation is socially determined and that this perception can alter over time. She goes on to underline that the social body “constrains” the ways in which the physical body is perceived and that this results in continuous exchanges between the two bodies about the current meaning endowed.

This concept of blood being a natural symbol can be examined in relation to aspects of the dialogue from respondents who may infer that blood has acquired new “non-natural” symbolism in the twenty-first century, which is reflective of the ways that society has begun to use blood and what it represents. Blood is symbolic of both “bio-hazard” and gift. Blood, therefore, as a natural symbol undergoes this continuous cycle, thus current meanings need to be reinterpreted. Douglas (1996) has also alluded to the ideas of exchange in society and these will be applied to the data gathered here.

Douglas (1996:10) argued that “Gift cycles engage persons in permanent commitments that articulate the dominant institutions”, which in this case applies to biomedicine. This is pertinent to blood, as Chapter 2 has illustrated.

Blood can be regarded as a cultural as well as natural symbol (Douglas, 1966). As such, therefore, it is subject to a differing set of social rules and sanctions over time. This is what V Turner (1974) termed a “multi-vocal” symbol. The case of bad blood being donated became a theme later in the research as the identification of disease (variant CJD) was found in the supposedly clean blood supply. This endangered the whole institution of the NHSBT, whose role of monitor of who can give blood is socially sanctioned (HPA, 2007). This led to greater surveillance to keep the blood supply clean and safe. For a time, therefore, it is argued here, donated blood was liminal in the UK. Liminality carries social penalties, and for a time blood supplies were affected by distrust and people feared contamination from blood transfusion. This led to a rise in autologous transfusions whereby people who required blood replacement following operations pre-donated their own blood. This is discussed later in Chapters 5 and 6, where ideas about “gay blood” and blood from other groups such as the elderly being liminal (Van Gennep, 1960) are discussed.

Themes such as risk and community cooperation have been examined by Lupton (2003) and Caplan (2000), who revisited the concept of risk in relation to cross-cultural comparisons and the differences between lay and professional ideations of risk, and can be related to the rise of surveillance society and the growing concept of citizenship. In relation to blood, this has meant, for example, donors willingly removing themselves from active donorship if they are unwell. The relationship blood has with contemporary society is one that is centred on and around the idea that blood is a renewable substance as well as being transferable between both people and communities. It is this dual capacity that sets it apart from other body parts and transplantable components of the

body. This idea of healthiness as somehow linked to successful negotiation of risks to the body from and by society is carried forward through using narrative from the donors and other respondents in relation to keeping the blood “healthy” enough to donate. The new body is exposed to new risks in the form of unhealthy blood becoming a risk to both the host and potential recipient, for example from blood donated by homosexuals, despite their sexual behaviour being no more risky than that of heterosexuals.<sup>10</sup>

Fox (1999 cited in Lupton, 1999) has reflected on postmodern risk in relation to lifestyle choices, changes in social construction of risk and the understanding of what a risk actually is understood to be. Fox uses the concept of hazard rather than risk of contaminated blood to illustrate the change, using the work of Grinyer (1995). Hazards are linked to the natural world, unlike the man-made risk, and as a result carry a different level of tolerance. Grinyer examined the tensions between lay and scientific dimensions of risks associated with blood needle stick injuries. Her work concluded that risk perceptions are multi-dimensional, with scientific and official information being only one way of how risks are managed, and that powerful social forces are what really shape the reaction. Lowe and Ferguson (2003) explored ideas about perceived risks in relation to blood donation, especially autologous donation. Autologous donation is being used increasingly as a risk management tool whereby the patient donates their own blood prior to surgery, thus reducing the risk of mal-transfusion. Their study revealed that blood donation was deemed to be a safe procedure but not without risk, and if asked

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<sup>10</sup> [www.telegraph.co.uk/health/men\\_shealth/3354388/Finger-on-the-Pulse.html](http://www.telegraph.co.uk/health/men_shealth/3354388/Finger-on-the-Pulse.html)

donors would prefer their own blood, or a blood substitute if there was any risk made known to them.

A further theorising of this idea led to the understanding that people are now concerned with keeping individual parts of their body healthy and risk free, a corollary of how the sick body part has been described in the past (Mol, 2007). This is analysed in Chapter 5, whereby donors express ideas concerning keeping the blood healthy as if it were separate from the body.

### **3.2.4 Citizenship**

The concept of citizenship has become the cornerstone of the contemporary public health agenda according to Petersen and Lupton (2000:61) they argue that the concept of citizenship is a term that is contingent with the demands of the surrounding society. As a result, modern citizenship is a both conscious and increasingly corporeal attribute. To take into account the societal demands of the body in society, Petersen and Lupton (2000:62) argue that “The contemporary meanings of citizenship are closely aligned with notions of the civic and the civil and are intertwined with the relationships between citizens, the common public life and the city.” Therefore it is imperative to reflect on the term citizenship in relation to the changed nature of blood donation. Citizenship has developed from its early associations with community and solidarity to being linked to obligations and regulation of the individual over the majority (Miller and Rose, 1993:98 cited in Petersen and Lupton, 2000:63). A key aspect to this new representation of citizenship is the relationship with self discipline, and it is this aspect that will be applied to the concept of being a blood donor in contemporary British society.

Tilly (2006) reviewed the concept of citizenship as a form of social ties and linked this to a collective identity formation. He has also examined the development of citizenship in relation to what he termed “trust networks”, which it is argued here that the NHSBT is a form of. The NHSBT as the articulation of trust in the modern world of transfusion of blood has replaced the notions of individual trust, and it is a further way in which the notion of citizenship can be applied to the world of blood donation.

Risks associated with the blood supply in the recent past have reconstructed the characteristics of the ideal donor to incorporate these changed understandings of who the donors donate for and to whom, as well as to why they donate in the first place. Contemporary constructs of citizenship incorporate notions of equality and equal partnership in society. However, I argue that within risk-related discourse, citizenship is also concerned with knowing when to respond to pressure to abstain from full participation in what would have previously been understood to be areas of individual choice. Larkin (2009) argues that citizenship is relational, in that individuals are seen to be actively connected, thus sharing citizenship which demonstrates and generates mutual concern and solidarity.

The idea of blood donation being related to the capacities of a good citizen was included in the thesis of altruism through which Titmuss (1997) explained why people took up the mantle of blood donor but in the style of that of a good Samaritan doing good for others. The background of the inception of the blood donor service was bedded in to the emergence of post-war “Marshallian” (1950) mode of citizenship. This was divided into three parts; firstly, a civil component related to individual freedoms such as freedom of speech and the right to a just society, then a politically based element related to rights to

participate in the political mechanisms such as local and national ballots and votes, and finally a more societal component as the right to live and enjoy economic security in a civil society were regarded. These notions or expectations of a citizen-led society were managed or expressed through the institutions of state control to effect the carrying out of citizenship roles and responsibilities via the police and social welfare institutions, for example. Despite criticism of the Marshallian citizen (B Turner, 2001), it is easy to see how the new role of blood donor slotted into the “rights” element, with the “right” to give blood being established alongside the fledgling blood donor service in the UK. The ideas, functions and characteristics of citizenship are well documented (Powell, 1992; Isin and B Turner, 2002; B Turner, 2008). The literature on citizenship is well related to the research question as the changing definitions of citizenship have had an impact on the perceived and actual role of the blood donor. B Turner (2008:198) has critiqued the links between citizenship and what he terms “associationalism”, arguing that in contemporary society there is no longer the networks of fraternities and communal associations to which Titmuss (1963) compared the public activity of blood donation located in communal halls. This erosion of this type of social capital system is also problematised by Putnam (2000). Both Putnam and Turner situate the action of blood donation within the context of a civic or voluntary association, and then argue that the collective associationalism form of citizenship has been eroded or elided by modern concepts of citizenship and a newer understanding of community engagement linked to modern democracy and the management, in particular, of risk. Blood donation had masqueraded as a voluntary altruistic behaviour as a result of its location at the outset in church halls, by having no population-level sanctions at its outset and by being

constructed as a purely voluntary event. These ideas, it will be argued throughout this thesis, have altered over time.

As an addition to the active citizenship debate, Powell (1992) added the arrival of “hyphenated” citizens. He argues that the issues of consumerism and choice have become central to policymaking and in relation to blood donation, and in the emergent blood market economy this concept turns the altruistic voluntary giver into what could be called the “donor citizen” alongside the consumer-citizen, and it is this development that has led to tensions in the system as well as the perceptions of what it is to be a blood donor. The role of altruism versus citizenship is a central area of development for the research question.

The role of the NHSBT, rather than the organisation itself, is examined in supporting and controlling the new role that blood plays in society and how donors can be constructed as donor citizens. The Service has widened its scope and gaze of the body since its inception. It was charged with the collection and distribution of human blood at the outset. Now it is charged with what I would argue are the recirculation of blood and its body products and subsequent components. It is, thus, a centre point for blood’s new relationship with modern societies. Demands on the service have led to more “unnatural” uses of the donated whole blood. An example of this is the project to salvage more blood, lost during surgery, in order for it to be used again.<sup>11</sup> Copeman

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<sup>11</sup> HSC 2002: “Better Blood Transfusion Cell Salvage During Surgery”.



(2005:469) turns to this theme of blood management, as it is pertinent to the concept of blood as a gift, and who is responsible for its management in society.

Healthiness and its attainment is a major cultural and public health concern in the West and increasingly in the developing world. As a concept, health has been examined at intervals throughout time to explore various connotations including “health is wealth” and “health is status” (Dubos, 1996; Petersen and Lupton, 1997). However, current arguments are linked to the rise of what has been called “the new public health”. This idea incorporates the growing concept of citizenship to the healthy citizen and the rise of active rather than passive participation in attaining and maintaining health for blood donating purposes.

Medical anthropological analysis of health and health systems is of increasing interest and significance to other disciplines (Helman, 2003). This is due to the growing impact that “health”, its definition and its maintenance, has in contemporary Western societies. Further ideas about health are found in relation to the body normal as well as the body social and political (Kleinman, 1980; Hahn, 1999). The relationship of blood to ideas about health is under-documented, and this research presents ideas about this relationship, exploring the idea of health and healthiness transmitted via blood or its products. This developing concept of how the body is related to health is in need of exploration, as there are ramifications for blood donors to maintain their health in order that the blood can be used as a resource for health rather than for simply lifesaving as used to be the case in the past. The relationship, therefore, which exists between the NHSBT and the public, makes it one of a screening and surveillance service, thus linking this to concepts of citizenship and surveillance society (Lyon (ed.), 2006).

### **3.2.5 The Body, the self and blood**

Copeman (2005:466), when reminding us of the explicit usefulness of blood, highlights the taxonomy of the body product. Blood has become embodied so that it has its own social and political bodies. Blood, when circulating outside the body, becomes in fact more important. It treats deficient bodies that are in need of its hidden powers; it is separated out to produce more power in the form of fractions of itself: factor 8, white cells, etc. This is relevant for the later part of my thesis, as donors were indeed becoming aware of the power of the blood when circulating outside their bodies, and in concordance with Copeman (2005:468), especially when their gift of blood was of a rare type.

Franklin and McKinnon (2001:68) have revisited concepts of kinship in relation to new technologies, and their paper has relevance for my study in relation to the concepts of man-made blood to which I refer later in Chapter 8, “Blood Donation, the Body and the Self”. Franklin argues that the technological advances are in effect capable of rewriting the scripts of what is nature and what is culture. Echoing the resurgent interest in the body in society, writers in recent publications have examined the position of blood as a form of bio-capital, citing umbilical tissue as an example. As a result it has become involved in the extensive body part exchange systems in the transplant economies of the Western world (Gold, 1996; Scheper-Hughes, 2002a; Lock, 2001, 2002; Franklin and Lock, 2001). More recently, this interest in body part economies has been in relation to blood-borne infections, waste and misuse controversies (Waldby, 1996; 2000; 2004). Rabinow (1999) introduced the concept of “bio-sociality”, which describes the bonds of new communities being grounded in the new biotechnologies. This can be applied to

my findings in particular relation to recipients of the increasing array of blood components. Busby (2004) examined the process of blood donation in relation to blood donated for genetic research, and added to the debate in this area problematising the very recent issues concerned with donations of body parts to further genetic understanding.

Presenting the idea that blood and health were related, and blood donation may be construed therefore as a form of donation of what I term “second-hand health”. The donors have to be healthy enough or in good health in the first instance to be able to offer this second-hand healthiness, and many of the accounts described how they keep their bodies in good enough “shape” to be utilised by others who were by and large deemed to be less fortunate than the “healthy donors”.

The organisation and management of body part donations has led to a new role for the body in society. That of a provider of “second-hand health” in the form of body parts, both solid and liquid, is a central area for academic and ethical debate (Lock, 1993; Haraway, 1991; Fox and Swazey, 1992; Weiss, 1999). Synnott (2003:4) has succinctly encapsulated the predicament of the body and at the same time raised the social dilemma for the body and its parts. He argues that:

the body social is many things; the prime symbol of the self, but also of society, it is both subject and object, individual and personal, it is also an individual creation, a cultural product and also the property of the state.

This has resonance for donated blood, as the pooled blood collected is the property of the state.

Strathern's (1992:73) work *After Nature* was an important start to the debate concerning the rise of the new genetics and what it might mean to the concepts of kinship. This has resonance for blood as much as other organs in the current era (2010). The accepted definition and symbols of kinship are now being rethought in circumstances involving blood. For example, Strathern (1988:180 cited in Munro, 2005) argues that social transactions make social relations afresh as a result of the modern uses of blood. Her concept of merography, which may be defined as a sharing of bodies to create what she calls "part-whole relations", is relevant here. This may be interpreted to include the idea that givers and receivers of blood as a result of entering into the blood donation social system are by default entering into "part-whole" relationships with others (Franklin, 2001). This has implications for kinship in relation to receiving literally life-saving blood components from non-kin; e.g. bone marrow for the treatment of leukaemia and factor 8 for haemophiliac disease are both blood derivatives (Franklin and Mckinnon, 2001).

Therefore, I am arguing in the thesis that not only is the new body individual, the new blood is too. This thesis provides evidence of this new body, the liquid body, and serves to problematise it for discussion.

Myths and beliefs about blood are deeply embedded in many societies. Skultans (1970), Fox (1985), Strathern (1988) and Holy (1996), in their work about English kinship, illustrate some interesting explanations about the perceived properties pertaining to what traits can be "passed on" through the blood. Strathern (1995) cites the work of Wolfram (1987) and the simplified ways in which genealogy is talked about. The blood is thought to flow in equal quantities from the contributing parents and grandparents so

that literally one is “made up” of quarters and halves of blood as well as other inherited material. The blood itself is not visible, but its qualities that go to make up the new individual are expressed in traits (Strathern, 1995:80). Elster (1990:46 cited in Healy, 2000) postulated that blood donation is the purest example of altruistic behaviour, whereas Waldby (2002a:305) articulated that a shift had occurred in what had become “social indebtedness” in relation to the new bodily relations. This now includes blood relations. Social indebtedness has ramifications for citizenship, both in who can give and how the gift is managed.

According to Waldby (2007), this new type of social system could be a form of “organic solidarity”. The original blood system created by the initial transfusion service could, therefore, be viewed as a form of “mechanical” solidarity (Durkheim, 1984). Blood donation may then be viewed as insurance for society for further research, as well as for use in saving lives immediately.

Weiner (1992 cited in Osteen, 1995) argues that in gift economies what motivates reciprocity is the reverse of simple giving. The concept of inalienable possessions identified by Weiner asserts that objects are culturally imbued with a spiritual sense of the gift giver. This concept of “giving to get back” could, it is argued here, be seen as a version of this theory. Increasingly, as blood becomes objectified and is regarded as a bodily possession in the prevailing blood economies, the gift of blood cannot be alienated from the giver, thus echoing Mauss (1990) that the contemporary blood donation is a loan rather than a gift as the giver does not “abandon” their donation once given: the transference from one person to another creates meaningful bonds with the giver. The gift relationship concerning blood has become inalienable, rather than

alienable, due to the change in the relationship desired by the giver in present-day donation discourse.

### **3.2.6 Commoditisation and capital: “McBlood”**

Investigating cultural coding surrounding the body and blood cannot be fully understood unless theories of globalisation are related to it. Ritzer (2006) reflected on the rationalisation of the world as related to Weber’s (1964) bureaucratisation thesis. He called this McDonaldisation, and if we look at ways in which contemporary societies manage blood it is possible to say that blood has been McDonaldised.

As global issues concerned with blood donation and supply becoming dependent solely on voluntary donation came to the fore (Coleman, 2004), international agencies such as the World Health Organisation (WHO) changed perceptions and presentation of who and what constituted a safe blood donor. In 2004 the WHO began to focus on the changing needs of populations in relation to blood supply and how it was donated. The establishment of a “World Blood Day” (WBD), which was dedicated to the uses and procurement of human blood, is a useful starting point to illustrate the changes I propose have occurred. A discussion of the differences from 2005 to the present (2010) is included in later chapters as a way of illustrating the changes alluded to. The 2008 World Blood Day had a theme: “giving blood regularly”. This slogan was created in order to support donor programmes to build a stable base of “safe” donors, referring to those whose healthy blood and lifestyle would demonstrate a commitment to regular

donating. This campaign was supported by slogans such as “Once is not enough”, imbuing once-only donors to becoming regular donors.<sup>12</sup>

The objectives that accompanied the WBD 2008 are interesting in relation to the premise of this thesis in that the issues around safe blood have been replaced by the new focus on safe “donors”. WBD 2008 had three broad objectives: to remind the public of the “short shelf life” of blood, to promote recognition of the fact that blood donors were in fact healthy individuals who were screened regularly, and, finally, to highlight that donors led healthy lifestyles.

It is argued here that World Blood Day is a form of globalisation, and the processing of blood conforms to the four principles of McDonaldisation. Blood is processed and packed in an identical way across the globe. The other principles of McDonaldisation, efficiency, calculability and predictability, can be applied to the Blood Service in that the work is related to targets and strict policy (DH, 2010). The packaging, nomenclature and measurements of blood conform to the third principle of McDonaldisation: that of products being served up in the same way wherever you are in the world. The final aspect of the McDonaldisation thesis is that of control being passed from human to non-human. This aspect has not fully materialised at the shop floor end of the Service in the sessions where I did my research, but the laboratory-based component services are in

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<sup>12</sup> [www.who.int/worldblooddonorday/archives/2006/en/index.html](http://www.who.int/worldblooddonorday/archives/2006/en/index.html)

the process of becoming non-human operated. The Bio Products Laboratory (BPL) is the embodiment of this aspect.<sup>13</sup>

Shilling (2003) examined the problem of the commoditised body, thus highlighting that the body has become the site and source of both biological and physical capital (Bourdieu, 1972). This idea will be extended in this thesis, arguing that blood is worth more out of the body than in it, especially blood deemed rare due to its blood group, and so arguing that modern bodies have “blood capital” as well a body capital

As blood has become more potent as a commodity than a functioning body part, following its gifting it has developed a form of “sociability” (Arapachi, 1998). The argument will be developed through this thesis in relation to ideas about blood as a form of human capital and its developing social life and the subsequent alienation of the donor from their product.

Marx (1978) highlighted the enigmatic quality of commodities in capital; he states that:

A commodity appears, at first sight, a very trivial thing, and easily understood. Its analysis shows that it is, in reality, very complicated in so far as it is a value in use, there is nothing mysterious about it.

As Marx asserted, it is the “origin” of commodities, rather than the process that generates them, that so often remains obscure. The mysteriousness of commodities lies

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<sup>13</sup> [www.bpl.org](http://www.bpl.org)



in the fact that “value” does not always present itself initially, and so instead it “converts every product into a social hieroglyphic” (Marx, 1978:321). In the case of blood we may use this concept from Marx, as especially in relation to blood the commodity is so altered by medical and technical processes that it is hardly conceived to be the same thing, i.e. a hieroglyphic. This view of a commodity relates well to the focus of this thesis on blood and how it has altered to become a multi-commodity and thereby distanced from the body so much that many donors may not regard blood as part of themselves. They regard it as a necessary product which needs to be extracted from the body for wider usage.

### **3.2.7 Biomedicalisation and biopower**

A Foucauldian (1977) perspective will develop the objectives and findings of the project, in particular the medicalisation and the notion of the “gaze” perspective. The Foucauldian perspective concerning the “medical gaze” (Foucault, 1977) is a particular aspect of the perspective I wish to apply to the social forces, which monitor and control blood donors, blood donation and how the power base for control of blood and its utility has been dominated by at first biomedical control and latterly the control of a safe blood supply that has passed to the donors themselves as the “gaze” turns to the subject (Foucault, 1977). Foucault (1977) theorises social action as individual agency, arguing that social regulation and interaction is concerned with power. He traces the changes in individual perception and interpretation through the rise of scientific knowledge at the expense of the previous source of power, religion with “God” at its epicentre. The regulation and economy, and latterly sickness management in societies, was through the control of specialised knowledge found in biomedicine and other closed professions.

Any individuals not “acting” appropriately were excluded from normal society by the use and sanction of these power bases. The body in society, therefore, for Foucault was not the embodiment of reason but of management and control of the physical body. The embodied self was a willing partner wanting to be regulated and controlled, sexually and mentally, as well as bodily. This has resonance for my research in the way in which the donating body has become regulated and, if necessary, excluded from donating. Society saw alterations in behaviour that sought to keep the body private, continent and under the scrutiny of the professions (Foucault, 1977; Armstrong, 1983; B Turner, 1995). Foucault comments that for a society dominated by death, blood constitutes one of its fundamental values; blood was instrumental in preserving order, and through its shedding, creating disorder. He compares “sanguinity” to society in that people are through it a society connected by blood. He argues that power can speak through blood: “Blood was a reality with symbolic function” (Foucault, 1975 cited in Rabinow, 1984:269). Conversely that modern society is dominated by life and blood is still instrumental in preserving order and emblematic of social control of bad blood.

Biomedical consumerism has impacted on the body part as much as it has on the body whole, claim Dickenson (2008) and Sharp (2006), who alert us to the new body for sale, more especially in parts and latter fragments or components. This concept is developed in Chapter 8 “Blood Donation, the Body and the Self”.

Howson (2004) examined the commoditisation issues raised by the medicalisation of bodies. This relates well to the concurrent medicalisation and potential commoditisation of blood, although the commoditisation, it is argued in Chapters 7 and 8, occurs not as a result of voluntary donation but because the blood becomes further commoditised; each

time it is split up it becomes something else, e.g. factor 8. This demonstrates blood's new role as a quasi-medicine rather than simply a body part. Presentations of modern blood are in fact one of a man-made body part which is becoming perceived as being non-natural; this is uniquely a feature of extracorporeal blood.

Blood has also fallen under new auspices of biomedicine, becoming medicalised into a new speciality of blood component therapy. These changes are powerful examples of the changing nature of society and how we perceive the individual and the social self in contemporary society. Blood may have been seen in the past as a part of the body, but that perspective is now changing. This is due in part to the fractionation or breaking down process, which transforms blood into many reusable parts.

A further facet of the changing nature of blood and blood donation in contemporary British society is the impact of transplantation and transfusion technology, which has made the once impossible not only possible but routine. The using and "sharing" of bodies is commonplace in bio-medicalised societies and has been well documented in social science related literature (Fox, 1992; Lock, 2002; Waldby, 2006; Waskul and Vanini, 2006; Sharp, 2007) this has taken the analysis to a different level by examining tissue donation and even donation of those parts previously considered as waste products, e.g. umbilical cord blood. This may be suggestive that the gift of blood has been "watered down" to allow its conversion from mystical to the mundane removal of a functional body part. This aspect is revisited in Chapters 5 and 8.

### 3.2.8 Man-made blood

Earlier in the review of the literature I argued that blood and the transfusion and donation of it is at the intersections between nature and culture, and it is to this idea that I return. The process known as “fractionation” is where whole blood is broken down into parts that are essentially stand-alone body parts, what I termed “man-made”. This idea of man-made blood was developed and analysed via fieldwork narratives in relation to what I term “a developing hierarchy of the self” and is linked to the “technicalisation” of blood. This, it can be argued, symbolises the emergence of blood as a collective social fluid (Cregan, 2006:93) which is harvested, stored and pooled for redistribution. This will be analysed in the later chapters, arguing that blood has gone further in the medicalisation relationship and that it has indeed become a “technical tool” (Mauss, 1990); blood itself has become a technical tool separate from or in addition to the body. This has ramification for applying the concept of inalienability espoused by Weiner (1992) and whether donors are related to the spirit of their gift after it has been not only donated, but also altered as a result of the processes used in the redeployment of blood into both the marketplace and the blood supply. As a result, there can be two uses of blood, natural and unnatural, as per Table 1.

<b>NATURAL</b>	<b>UNNATURAL</b>
Replacing accidental blood loss	Selective replacement of cell line
Donating whole blood	Selling blood
Family use of blood	Genetic reconfiguration to avoid disorder
Healthy to ill	Healthy to deviant (e.g. drug users)

**Table 1: Natural and unnatural uses of blood**

If the body has been acknowledged as the “natural tool of man”, it can now also be said to be the natural “marketplace of man”. Scheper-Hughes (2001) introduced the idea of the new body in society as commoditised, and focused on the “new life” of the body and its parts as investigated by metaphors, speech, symbolism and the social body. I would like to take this metaphor further by illustrating that blood also has a “new life” after it leaves its body; the new life is carefully managed by the medical profession. This de-alienation process is expanded in Chapters 7 and 8.

The donated body part world has raised bioethical concerns. Gold (1996:13) offers some ethical commentary on both the body and blood. He argues that the body has authentic good conferred upon it by society and this is manifest in diverse ways as well as in intensely personal ways. It is a representation of who we are, and for some the body is the expression of a higher order (God). Therefore, society values the body as a whole, but also increasingly in and for its contingent parts. Whilst these parts are not autonomous, the body is being broken down into both visible and microscopic parts (e.g. DNA). Gold further highlights that this inherent “goodness” of the body can be used in aiding human health. He cites blood as an example of being symbolically representative of life as well as becoming valuable as a “health preserving product” once it has been broken into its therapeutic parts (e.g. factor 8, plasma, etc.). This is an important ethical development in the way pooled and individual blood is regarded, and one which this research hoped to discover testimony about. While blood parts do not carry the same value as does blood as a whole, it is argued by Gold that we do value blood parts for what they represent in being a “symbol of community” (1996:12), and thereby strengthening the growing link between body components and health.

Gold postulates that, rather than blood as a symbol of life losing its power via its transformation from whole blood to blood parts, in the doing of this the value society places on blood must increase, as blood therefore confers life to the recipient on behalf of society and not the donor.

The ethical issues surround the concept concerning whose blood it is in the first place and who this multiple body part belongs to. The property discourse was embedded in the solid body part debate, but it is argued here that the transformation of donated blood increases the original fluid's value more than the volunteer donors understand. As evidence of this new world of donation, the Nuffield Institute working party on body and bioethics is worth referring to.<sup>14</sup> Its purpose is to identify and debate ethical issues caused by recent advancements in biotechnology and donation of human tissues, body fluids or solid organs.

The NHSBT should therefore make more widely known what happens to the whole blood that is collected. Busby (2006) has argued that the existing status quo of bio banking has been built on the pre-existing premise that blood is donated for the public good as a utility. In the course of my later observation it became an area of interest to ascertain whether donors knew what happened to their blood after its donation; this is discussed in Chapter 8.

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<sup>14</sup>[www.nuffieldbioethics.org/sites/default/files/files/Human%20bodies%20in%20medicine%20and%20research%20consultation%20paper\(1\).pdf](http://www.nuffieldbioethics.org/sites/default/files/files/Human%20bodies%20in%20medicine%20and%20research%20consultation%20paper(1).pdf)

Exchange systems and bodily cooperatives are not new, but the dividing and sharing of the actual physical body parts is new and it is dependent on and mediated through modern biomedical hegemony (Csordas, 2001). Science, particularly biomedical science, is at a new interface with both nature and the body physical. Science now provides a cellular and prenatal concept of the body as a result of experiment and genetic research. This has an impact on the ownership of the body. Martin (1992 cited in Csordas, 2001) argued that we are undergoing fundamental changes in how our bodies are organised and experienced. My research adds to this by arguing that we are undergoing a fundamental change in how we regard bodily parts in relation to the self. Lock (1993) argues that the body mediates all action and reflection from the world and that, despite the problem of bodies, the significant argument surrounds what delineates the body and how it is cultivated since its discovery in a sociological sense in the new body share world.

Therefore, consideration as to what delineates or comprises the body in this spare part world is pertinent to my study, as part of my theorising in this work is to highlight what “delineates” blood. For example, when does blood stop being blood? Is it as it is bagged up or is it when it actually leaves the host body. A further question is whether blood is still blood when it is pooled into tanks for fractionation procedures, which turn it into the new man-made blood and its constituent parts. These ideas are discussed in Chapter 8, “Blood Donation, the Body and the Self”.

Other commentators have examined the area of genetics and blood for research aspects of blood donation, for example Tutton (2002). This study of blood donation from a community and genetic perspective adds further to these areas in relation to the

interpretation of the reasons and rationale for giving blood outside of the altruistic perspective, to present new ideas about what people feel and do in relation to blood donation. Hoeyer (2002) found that even those knowingly donating blood for genetic research solely had limited understanding of what their donation was used for, saying only that science and research was really in need of blood micro-components. Blood donation helping towards this important function of medical science was sufficient explanation.

Other studies in this area (Waldby, 2004; Scully et al., 2006) have focused on the moral or ethical issues related to blood donation rather than corporeal and cultural issues that are the focal points of my study. Waldby et al. (2004:1462) have linked the impact of burgeoning tissue, organ, blood components and body fragment transplantation to issues surrounding what they term “bioidentity”. They assert that bioidentity describes what has come to be understood as a common-sense understanding of the body as “ours”. Popular understanding of where the individual body starts and ends is changing due to this rapidly growing “timeshare” of bodies through the biomedical practice and technology. This process also, it is argued here, has influenced what is considered the true self, the self-identity.

### **3.2.9 Biomedicalisation, the body and the self**

The medicalisation of society and the centralised role of biomedicine as an agent of social control (Foucault, 1977; Lock, 1993; B Turner, 2001; Armstrong, 1995) have, it is argued here, altered the symbolic meaning of blood in contemporary society. The action of giving and receiving blood and its products presents opportunities to assess the current meanings attached to these actions. The metaphor and symbolism of blood



according to Foucault is an important element in the mechanisms of power, both in rituals and the ways blood literally links communities together. The change identified in this thesis is that the role of panoptic controller played by the NHSBT has been taken up by the actual donors. Blood ties as kinship have, I will argue, been replaced by a new form of social alliance. By this I mean that the redistribution and reconfiguring of blood as a body part has created a new social alliance between those who give and the rest of society. This will be further explored in the part on mutuality in Chapter 7.

In the past, as the reductionist biomedical paradigm took hold the body began to move away from the self, especially in times of illness or disease. Cassell (1976) examined the language used by sufferers to describe the dysfunctional “part” of oneself or the body. The use of “it” rather than “my” or “mine” gives the part an identity of its own. The view is of the disease as an object, not part of their whole self. Cassell (1976:144) cites that even in something as diffuse as thrombophlebitis, the disease is regarded as an entity; the disease becomes an object able to invade the sufferer’s leg. The diseased body part is separated off in the language used by the sufferer to describe the event. It is operating within her but not affecting herself. The body is viewed as separate in each person’s mind; for example, Cassell (1976:145) states that the sufferer at once depersonalises, and personalising an illness such as “my diabetes”, but key organs always remain part of the self, e.g. “my heart”.

The purpose of this depersonalisation or distancing may be in some part concerned with the social functional and moral consequences of illness according to Cassell (1976:146). The argument is ontological rather than medical, but does have some bearings on what Western culture comprises as the “self” versus the body. Mol (2007) has echoed these in

her ethnographic accounts of sufferers' relationship with diseased legs due to arterial disease. This is in fact describing multiple "selves" associated with the body. In the case of blood this type of phenomena is occurring, so that blood can be both a vital part of your body but not so much a part of yourself that you are concerned about giving away.

In recent years the body in society has become problematised through issues and debate surrounding the sharing and revaluation of the body as metaphor (Crossley, 2001). B Turner (2008:36) argued that the body in society has been dominated by the impact of biotechnology. Foucault (1980a:172 cited in B Turner, 2008) argues that in fact it was the "biological traits" of the population which became relevant for economic management in the new industrialised societies, rather than bodily capability of the past. This notion can be applied to blood donation as the quality and immunological elasticity of the blood is now the new target of power and control.

I am arguing in this thesis that blood as a discrete organ in itself has undergone similar metamorphosis, illustrating the centrality and importance of the divisibility of the body. The body as a social construct will be analysed in relation to blood donation as the concepts of communitarianism and embodiment are reviewed from the fieldwork data in relation to an emerging "hierarchy of self".

A hierarchy may be defined or understood to be a tabulation in which each element of a whole (viz. the body) is graded or ranked. Blood, due to its self-replenishing properties, has slid down the hierarchy from an individual perspective. However, from a

population-level hierarchy blood, it is argued, has moved up as the value and the importance of blood and its products when outside of the body has increased in value.<sup>15</sup>

Sanner (2001) conducted a study exploring public attitudes towards the exchange of spare parts and the idea of becoming a new person. Her study of 1,969 respondents confirmed the conceptualising of the body as a machine and gave some insight into the prevailing attitudes about the willingness to give or receive donated organs from a variety of sources. The most interesting attitude was one of willingness to receive but not to give.

Merleau-Ponty (1962) argued that the body is not the same as the self. The impact of modernity has proven this true for blood donors. The process of donating is an embodied as well as a public act. People see you donate, although there is no overt expression of who donates or even a blood donor register, in contrast to public organ donation registers. How this action influences the individual affects how donors construct their self.

Dualism and the self as described here need clarification. In anthropology, the human body has several roles: physical, social, psychological and cultural. In contrast, following Cartesian dualism, the mind and body have been considered as mutually exclusive within the medical world. The relationship of the body to the self and how it is constructed is important in analysis of blood. Descartes' "automata", whereby the head and body were under different mechanisms of control, is the model which

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<sup>15</sup> [www.blood.co.uk](http://www.blood.co.uk)

preceded the contemporary ideas about the body as embodied or corporeal, as theorised by Scheper-Hughes and Lock (1987). Feeling and action were guided by separate functional parts of the brain; one did not affect the other.

Perhaps the newest challenge to the mind and the body, dualism, is the ethnographic work in the area of organ transplantation and the subsequent reconfiguration of the self, which takes place alongside and at the same time as the physical convalescence of the body. Sharp (1994; 2000; 2007) underlines this in her work highlighting that the body is not merely a cultural entity, rather, we assign highly significant cultural and social roles to the body and therefore to body parts such as blood, although what role is attached to blood is unclear from her analysis. As a result, the growth of spare part surgery must encompass some discussion on what occurs to the “self” when what transplantation means, in effect, is the receipt of another person, or part thereof. The way in which blood is re-deployed after donation, and even before, needs further explanation to understand what processes are occurring. Sharp (2007) focuses on the problematic sociability of body parts, and her concerns may well be echoed in future narratives of blood donors as the commoditisation process develops in relation to blood. Copeman (2005) reminds us of the explicit usefulness of blood and highlights the taxonomy of the body product.

Cohen (1999 cited in Scheper-Hughes and Waquant, 2006:1) argues that there has been developed an “ethics of parts” in relation to the new divisible, commoditised late modern body. By this he means that ethics and ethical stances that used to apply to whole bodies now are applied part by part, thus allowing market forces to dictate the value of individual parts. Lock (2001:69) further argues that market forces make blood

donating particularly vulnerable to exploitation due to the fact that donors are made to feel that blood is both a renewable resource from the body and easy to donate. This allows both objectification and fetishism for those whose blood is rare, for example. The debate concerning ethics of blood parts is not evident in the UK, perhaps because of the voluntary nature of the blood market. Weiss' (1999) concept of "inter-corporeality" can be applied to the relations created by the donating and distribution of the specialist components of blood. Special components of blood are sold to other countries, in particular factor 8, which is used for haemophilia<sup>16</sup>. Weiss is correct when she argues that no one is discrete in their identity, as the new person or "I" is becoming mediated by the interdependence of what Waldby (2002:239) has called "biotechnical fragmentation".

B Turner (2003) argues that historically the dominant concerns of society are expressed via the body; for example, ancient Egypt created and recreated the world from bodily fluids and order was recreated in death through the practice of mummification designed to specifically control seeping of bodily fluids from the corpse. Bodily metaphors, especially fluid-related ones, are employed to discuss problems in society. Synnott (1993:15) has succinctly encapsulated the predicament of the body and at the same time raised the social dilemma for the body and its parts. He argues:

The body social is many things; the prime symbol of the self, but also of society. It is both subject and object, individual and personal. It is also both an individual creation and a cultural produce, and also the property of the state.

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<sup>16</sup> [www.blood.co.uk/about-blood/how-blood-is-used/plasma](http://www.blood.co.uk/about-blood/how-blood-is-used/plasma)

Crossley (2001), in examining the emergence of the social body, provides a critique of Descartes that refutes the dualist concept in relation to the modern body. The body, because of its commoditisation and sociability, has developed, I would argue here, a further level of existence: the relationship it has within its own “body-part anatomy” as well as to its mind, what Scheper-Hughes and Lock (1987) have described as social identity.

Csordas (2001) argues that the body in anthropology needs refinement and that cultural meaning can be extracted from the ways in which society and culture treat and use blood as well as other body “products”. It could be that blood is emblematic of wider cultural changes, which support and are controlled by differing social groups and individuals. The position of the body in medical advances and technology has influenced the culturally prevailing concept of both health and its promotion and management. Helman (1988) argues that medical technologies are not only tools but they also convey meanings about society and its economics. He argues (p.65) that the state-of-the-art technology in the West expresses modern medicine’s desire to master and control the body.

This is not consistent with all cultures; in the West the body is seen and utilised as a machine (Helman, 1994), supplying spare parts and what I would term “second-hand health” for others in society. Thus, the body has reappeared, by the primacy of biomedicine in all areas of modern life. Health, and its attainment and maintenance, is the primary role for modern societies; by keeping the blood healthy, we keep society healthy.

### **3.3 Conclusion**

This review of the Literature has illustrated the wide and varied academic significance of blood, its donation and what current symbolism is attached to it. It has offered a variety of theoretical perspectives through which it is possible to challenge the notion that blood donation can be characterised as an act related to, and limited by, altruism.

This chapter has explored the literature related to blood donation and related topics such as kinship, blood symbolism and theories associated with the key themes of the thesis: risk, citizenship, the body in society, surveillance through medicalisation, and the relationship between blood donation and altruism as a social force and with citizenship. It has highlighted the scope of the literature in relation to the subsequent chapters and the overall research question. The concept of blood donation as a covenanted relationship to society rather than one of altruism is explored through these theories. The concepts and theories of citizenship are central to this thesis in relation to the limitations of altruism and the rise of the active citizen and the donor, citizen in particular, and are explored through revisiting the early notions of citizenship put forward by TH Marshall (1950) and others.

The literature provided analysis on a range of perspectives, all of which have been useful in contextualising blood in contemporary society. Although there was at the outset of the study no clear tranche of blood-related research to draw upon, the growing centrality of new blood as a commodity has given rise to more academic interest. The next chapter is concerned with the research process, its location and methodological considerations.

## **Chapter 4 Methodology**

### **4.1 Introduction**

The purpose of this chapter is to describe the methodological and ethnographic approach of the research and to discuss the process involved in planning the project and how the field was accessed in detail. It presents reflections of the researcher in the field and hopes to convey the context of the project. The data is generated from fieldwork at a nation health service blood transfusion centre in the South of England and is derived from the findings of 80 interview based questionnaires given to donors immediately after donating blood. The data was collected during the period 2004 to 2008.

The chapter will also explain the methods applied to collate and analyse the data. It also considers the ethical issues and how the location for the fieldwork was negotiated. The chapter provides detail into who the donors were and their characteristics, and presents the geography of the field and how they were recruited to become the sample. It will



conclude with commentary on the methodological successes and failures of the project and how they did or did not affect the data.

## **4.2 Negotiating a field**

The following describes how I negotiated the field within the National Health Service Blood and Transplant (NHSBT) and the difficulties encountered. The National Blood Service (NBS) was established in 1993 as a special health authority supplying blood from its donors to NHS customers, and in 2005 became part of the larger National Health Service Blood and Transplant (NHSBT). I knew nothing about how blood was taken and was surprised by the scope of the organisation as I began my initial enquiries. However, as my focus was expressly not about the organisation, the process of interacting with donors with such ignorance about the NHSBT was very useful as I felt no loyalty to the organisation and therefore could not relate to the facts as known by the respondents about the NHSBT, thereby reducing the potential tension between me and my informants. That is not to say that the donors assumed that I knew all about the Blood Service. Some donors assumed I was researching for the NHSBT. Despite the enormity of the task I had set myself, I was trying to identify what processes and protocols were required to access the correct person. This proved to me that the study of blood donation would be a good doctoral subject, largely due to its elusive nature; if I could not find out who to contact then it was likely that very little, if any research had been carried out in the Service in the actual donation sessions.

After consideration of where it was best to uncover social interaction concerning blood donation, the NHSBT, sessions became my field for gathering data and observations.

Finding out who to approach in the NHSBT was a laborious task. I researched blood donation on Google and accessed the website which was designed to give information to donors about when the next session was in their area. Contact details of specific people were unavailable and even when making direct contact via the telephone to the head office; it was difficult to find a named person to whom I could direct my research proposal. As a result, I went into the local blood donation session to see if anyone there would tell me who to deal with. It was a very awkward experience as I waited in the queue to make my request.

I was finally referred to a lady in a blue nurse uniform, who led me to the area between the public area and the donating area and asked a few questions. I showed her my University identity card, and she wrote down the name and phone number of the person to whom I must submit my request to carry out research. Contact was made finally after many phone calls to the regional head office. My contact was to be with the research area of the Service and the head research nurse dealt with my queries. I was surprised almost immediately at my naivety concerning the magnitude and scope of the NHSBT. I had no idea that the organisation was so large. Once again, I would argue here that knowing so little about my prospective field was a benefit, as it meant that I had no preconceptions to obscure my first impressions. It also gave me a “native” perspective as I had had to go where the potential donor has to in order to be able to give their gift.

### **4.3 Ethical issues and permission**

Ethical issues are now of greater concern than they were in the past, perhaps as the social conscience and awareness of academic processes and the World Wide Web mean

that no research can be done in the isolation of the past. Ethical concerns should be a special focus of any research process. The issue of confidentiality and informed consent were largely absent, as the donors attend sessions entirely voluntarily and would only take part in the project if they wished to. Any queries relating to their interaction with me could be clarified by them making use of my full details which were available to them in writing and by e-mail. After discussions with the consultant nurse and medical consultant by telephone, it seemed that they would be supportive of such enquiry taking place within the donor sessions.

I was asked to submit to their ethics meeting the questionnaire that I had proposed, as they admitted to an interest surrounding the issues to do with several themes of my intended research. I submitted my professional and personal details and research design, including an example of the pilot questionnaire for scrutiny and approval, at their internal ethics meetings as requested. My presence was not requested in person, as I had discussed the intended questions and themes over the telephone and via e-mail with the research nurse prior to the meeting.

Initially there were queries about the purpose of my research. The concerns were centred upon the following: would it be detrimental to the collection of blood at the sessions, would it deter volunteers, would it upset the volunteers or staff.

Changes to the questionnaire were requested to make it simpler to complete, so that only the reason for donation was asked, as the research nurse said I would not have time to ask more because the sessions were likely to be too busy. The issue of notice of a research project taking place was dealt with by the reception staff saying that a researcher was present at the tea table and participation was not compulsory. I had to

display details of myself on headed notepaper of the University and display the letter on headed notepaper, which proved my authenticity as a sanctioned researcher. I had to also state in the information about myself that I was not employed or funded by the NHSBT.

After their consideration, I was given written permission to attend any session in the Oxford region. I was given the mobile number of the research nurse so that I could telephone in advance to say I was attending sessions. I agreed to sit in the recovery area for purposes of health and safety. Updated permission was received at intervals from the research nurse and the manager by telephone and the upgrading document for this thesis was given to the research nurse to read. Ethics approval was reaffirmed by universities' internal procedures.

Undertaking ethnography in the local transfusion service produced similar complexities concerning the dilemma about doing ethnography at home, with several attendees being known to me. I had encountered this in my research project with breastfeeding mothers, and I was confident that being known to attendees would not jeopardise either them or me. Doing ethnographic research at your "home" carries certain risks in that the ethnographer is neither transient nor anonymous to the subjects of the research (Hastrup, 1987; Goffman, 1989). This produces certain anxieties for the researcher and the subject alike. By deciding to carry out my research in a centre near my home I was taking risks in the following ways. The donors may not have wanted to talk to me and as a result affect the amount of data I could collect. I did, in fact, know several of the donors on each of the occasions I attended, and I gave them freedom to either talk to me

or not and consequently some did and some did not. A further risk was that by knowing one donor and talking to them, I would potentially miss out on talking to others.

Providing demonstrable evidence of both my own and the informants' anonymity is difficult as it relies on trust. Donors were told that, the data gathered was the property of the researcher, but the details of any contributor would be disguised and the data would not be made available without the researcher's permission. The data would be kept in a secure drawer to ensure safekeeping of any personal details. I have said that no personal details were requested from the respondents; however, some respondents did write all their personal details on the questionnaire – phone numbers, addresses, and in some instances e-mail addresses.

#### **4.4 Research design and the field itself**

This section presents the design of the study, how my research site was created and the difficulties involved.

The research was ethnographic in design, employing unstructured interviews and questionnaires consisting of open-ended questions which were supported by observation and interaction. The interpretive approach combined with ethnographic methods, such as note taking, observations and recording of details, such as seating arrangements and timings, for example, allowed insight into the physical suffering of the donor and the emotional labour it requires. This can be illustrated, for example, by the observation of the body as the donors wait, are in the process of being bled, and in the language they use to describe their own self in the act of donation, which can be compared and contrasted across different donors.

The decision to work in this way was made after the pilot session. I would not be able to follow through the donation process of a donor or interview them individually, as the permission from the NHSBT did not allow me to this. The donor was asked: 1) how long they had donated; 2) why they donated; and 3) what their feelings were about giving blood. They were also invited to add any additional information, if they wanted, in writing and leave their details if they so wished.

I introduced myself to the donors and referred them to the research consent letter which I had been given by the NHSBT, and I wore a visitor badge. The donors decided for themselves if they wanted to talk to me and/or fill out a questionnaire. I informed them that they could just fill out a form and write their comments on it saying that all information was useful, or they could go through the questions with me. They could also just sit there and not take part. I also informed them verbally and in another letter on the table, of my credentials and that the project was not a part of the NHSBT. Each questionnaire was pre-numbered, dated and gender coded and was attached to an envelope for the donor to put in once they had finished. I referred back to another influential source, Spradley (1987:69), and presented here what his notions are of “concrete facts”; that is to say what I saw, heard, smelled and felt. This has enabled more of what else there was in the field to be presented, rather than only observations which I made, thus adding to the veracity of the data. Recording of tone of voice or emotions added to several of my respondents’ responses to reveal their level of engagement or lack of engagement with the process.

To complement this, the practice of taking field notes, coding the findings and contextualising date and time into the data enables less observer bias. The field notes

were added as jotted notes afterwards to allow my comments and observations (Fieldman, 2001).

The data presented in the upgrading process for this thesis was the analysis and interpretation of the pilot or initial interviews taken at the initial visit and literature search. I entered the field as a low-level passive observer according to the seminal classification of Spradley (1980) in line with the request of the NHSBT. The field for me was a church hall which turned itself into a field hospital for the collection of blood and the selection or rejection of people coming to offer their blood.

Although passive in essence, this type of status is an important way for ethnographers to enter the “field”. I found it quite exhausting to present myself as invisible so as not to disturb the field and at the same time create a dialogue with the donor helpers, nurses, reception staff as well as the actual donors themselves. Some sessions I left early as I was overwhelmed with visual and verbal information. At times I felt buoyant, at others deflated. The first session had provided me with enough information to confirm that I would be doing my thesis based on the data I gathered at the sessions. The structure of the donor sessions at the pilot session informed me of the difficulties I would face should I try to create a more structured encounter with donors. There was no capacity to interview willing participants in a private individual setting, and the pace of the turnover of donors would mean that I would have to hope they wanted to take part while they were “recovering”, eating biscuits and drinking tea or coffee at what was termed the “recovery table”.

#### **4.5 The structure of the sessions, the interviews and the “recovery table”**

Initially I had asked for permission to only observe, as I was hoping to glean data via the participant observation route. However, I was unable to secure a role of tea lady due to the complexities and constraints of the conditions of my permission as detailed above. I was, however, much luckier and was able to capture a steady sample of both male female donors, due to the busy nature of the sessions, with the combination of the self-completed questionnaires and interviews as well as observation. I decided to use a basic open-ended questionnaire for two reasons; the first was to facilitate as much data as possible, and the second to allow the respondents a chance to write down their stories in their own words, although the donors were able to respond orally as well. A third reason was that while one person was filling out the questionnaire it allowed me to access one-to-one discussion with other donors and also to make field notes and observations.

The questionnaires comprised open-ended questions and allowed space for written answers. They simply asked about why the donors were giving blood. It is acknowledged that this type of data collection favours those people who are literate. The interviews were designed to be short – as short as five minutes in actuality – due to the time constraints felt by the donors. The interviews were also designed to allow an as flexible as possible approach to capture the widest scope of comments. The constraints on permission meant that any other topics were raised by the donors themselves. Interviews were conducted face to face but with the respondents writing down their own thoughts and commenting back to me. This seemed to be the most expedient way given



the constraints in the pace and changing nature of the recovery table residents. The interviews were a dialogue between me and one donor at a time. I was assisting in their completing the questions as well as taking notes of my own to add detail to the process. Details such as body language and language use were noted as a further layer to analyse at a later stage.

The NHSBT granted permission to access donors in the blood donating sessions, but limited me to sitting at the recovery table. It is described next, and I argue that, this was the pivotal point in the whole giving and receiving exchange process. It is here at the “table” that the gift giver receives the thanks and the reciprocal gift. The ritual is visible and witnessed, and thus allows the gift giver to return to normal society. This is a literal table and seating area provided for the donors to recover from their labour. In my field site, this table was in the bottom right of the hall in front of the stage and visible to everyone. The rationale was to keep me in one place, but according to one of the staff donor helpers, as I talked to her walking to “my table”, it was: *to stop you causing accidents or getting in the way; we have so many donors here and tubes it is easy to cause a mistake.*

It was true that the space was small and, as I found out later, it became chaotic quite quickly. If I had been allowed to walk around I would have been a danger. The field was a labyrinth of people carrying tubing and apparatus to and from each bedside, shaking the collection bags and placing labels and colours on different bottles. The staff each knew what their role and function was, and after seeing the pace of their work I can now see why they were hesitant to have me attached to them; I would have slowed them down and distracted them from their routine. Therefore, despite feeling that the

table area would not be adequate as a field, it turned out to be the best place to talk to the donors, which was the main focus of this particular research. The “table” then, after some time of negotiation and initiation, became my field.

The structure of the sessions was the same each time I attended. I arrived with a photocopied set of questionnaires, put on my badge, and sat and waited. Those donors who wished to take part were given a blue dot envelope if they were male and a red dot if female. The questionnaires were pre-numbered to allow collating of my notes with the correct respondent during thematic analysis. I informed the donors of my research project, both verbally and by directing them to the file containing my details and the letter giving permission to attend the sessions. I had no strict process for how I could use the sessions; I wanted to see what unfolded, so I sat and waited.

The epicentre of the research was the “recovery table”. This was a ten-seat trestle table covered by a plastic blue table cloth. The table was situated at the bottom end of the hall in front of the stage; it was always in the same place pitched slightly to the right. A selection of plastic orange and blue chairs was set haphazardly at angles, just as the last occupants had left it. The table had a basket of biscuits on it, different types: ginger nuts, custard creams, bourbons and digestives. To the left of the table was the tea urn, a large hissing silver edifice. The tea lady kept it filled up at all times. At the side of the urn were packets of tea bags and jars of instant coffee, plastic cups and cup frames into which the tea or coffee cup was slotted.

The table was the place to where all those who came to donate were directed after they had finished donating. Sometimes donors were reluctant to add even more time onto the burden of donation, and the tea lady had to get a sanction from the person in charge to

have let them leave without recovering at the table. The table was at times brimming with donors and at others it was occupied by just one or two donors. One aspect of the table which was of note is that the donors never acknowledged each other, even when they had acknowledged me. This lack of camaraderie was broken sometimes as a result of my presence when a comment by one donor had provoked a response from another: the donors were not in the action of giving in a communal sense at the sessions.

#### **4.6 Geographical locale, place and space**

Following successful negotiation, I will start by giving a description of the blood donor setting, the physical geography, atmosphere and the people I met. The location was selected for reasons of typicality and it seemed representative of the iconic waiting room of the past. It was also deemed to be a typical demographic location. It was a busy centre, according to the research nurse, and one that would be large enough to accommodate a research presence on site.

The town where the study took place is a mix of old and new town areas and has a growing young population. There is also a mix of council-owned houses and a large proportion of detached houses. It is renowned for the local schools. The immediate area outside the church comprises the local amenities of shops, the library and health and youth centres. The fieldwork comprised more than 24 sessions at intervals ending in February 2008. The attendance at the sessions was rotated through different times of the day and different months of the year, to see if there were any differences in attendees and attendance. The sessions were in fact largely the same in the number of people attending and gender balance; however, the time of year revealed some differences

which are discussed in later chapters (e.g. Chapter 7). Some session attendances resulted in me not being given access to actual donors due to no one allowing me in. Other times there were only one or two people in the time I had allocated.

The setting, as I came to understand, was a typical experience and location in which to meet blood donors at the NBS. The hall in which the project took place was attached to the Anglican Church via a covered way, therefore the church itself was not visible as you arrived. The annex was composed of two halls that had been constructed at different times. The original social function of the hall was to gather the church congregation at social events and act to raise money for the church.

The NHSBT typically rents buildings like this, since they are affordable. The research nurse told me that the NHSBT hires the hall, usually a place everyone in the town or village knows, and at the inception of the Service the only place of community in many towns. As a result, in some way the presence of the Blood Service at this type of venue may act as a metaphor for the gifting of blood as a community act.

This church hall was situated on the main road of the affluent commuter town in which the fieldwork commenced. The original hall was from the 1960s and incorporated a stage and an ante area where the staff sometimes took a break, or if business was very busy it acted as a second holding area. It also had a small ante room with a refreshments service area and a mixture of wooden and plastic seating. This back-stage area of the original hall was connected by a corridor to the actual church, and some of the church offices were visible if the side doors were left open. In many ways the atmosphere of the sessions were affected by the proximity of the church. By this I mean that the atmosphere changed the nearer you got to the church. It was sort of venerable rather

than a possibly more clinical atmosphere. This conferred a quasi-religious overtone for the sessions to take place in and conveyed an old-fashioned atmosphere. This was a paradox, as the donor staff were working with cutting-edge blood fractionation technology which did look out of place in the rickety, dilapidated church hall. At times the pace of the sessions made me feel I was in a fete, as so many people were moving and turning around holding tubes.

The older hall was in a state of disrepair, especially the curtains. Some of the conversations by the donors were centred on the state of things in relation to infection risk. The newer hall was in much better, but still poor, condition. On entering the halls there were toilet facilities immediately in front of the newer hall, which had been built as an add-on in the mid 1970s. The hall had only a tiny refreshment area and was next to the fire station. The shabby state of the halls resonated in some way with the selfless, charitable notions of giving. The feelings described here may well have been absent in another more clinical venue.

The smaller hall was the initial reception area, and on transfusion days it was further divided into mini booths by leaded screens which the Service brought with it. The receptionist sat behind two tables, and her computer and other paraphernalia, such as leaflets and appointment lists, were spread out over the area. The remaining area was used for waiting and had rows of plastic orange seats set out in lines.

The initial atmosphere was that of hospital outpatients with an undercurrent of anxiety. Music was played on ordinary radio. At first I was unsure as to why. I had thought that in some way it was a tool for relaxing the donors as they waited, but I later learned that

it was to compensate for the lack of actual privacy in this particular setting. In other donation centres music is not played.

The process on arrival is as follows. You are “ticked off” on the appointment list according to the time of your appointment. Then the potential donor waits to see the donor helpers in a booth. Donor helpers are the trained personnel who staff the Service. They are not required to be nurses, although some of the ones I met were, and their training is almost entirely directed by the NHSBT.

I was not allowed into this aspect of screening, as the privacy of the potential donor is paramount, and visitors listening to the interview and testing processes may impact on the truth-telling of the donors. On one occasion I sat in the main reception area and could indeed see why this rule is in force, as I could hear snippets of conversation through the lead panel.

Chappelle (1940 cited in Whyte, 1984:84) has argued that ethnography is simply about who does what with whom and when. This is important when considering the task I had set myself. The first time I attended I was overwhelmed by the sheer numbers, both of staff and donors. I was also un-prepared for the complexity of the organisation and the speed of the sessions. I had no idea who anyone was or what they did.

One of the difficulties, initially at least, was in the temporariness of the field. The mobile units which set up and manage donor sessions can seem haphazard and irregular. In fact, often I only became aware of up-coming sessions when I saw the van or the plastic hoardings around the town pinned to lampposts or walls in designated community areas like the swimming pool. The van is very visible on each of the

occasions it comes to the town; it is a large bus-like vehicle, emblazoned with the NBS logo. Moreover, the NHSBT ties large plastic sheeting to nearby lampposts and street signs giving details of the session and the date and time of the next scheduled visit, so that everyone knew when they could go and donate. In actual fact this was not so clear cut, as largely within the organisation you can only donate by appointment, resulting in loss of opportunistic trade which can lead to issues such as deferment.

#### **4.7 The characteristics of donors**

It is important to introduce the body of actors in this drama so that a clear picture of what type of person contributed to this ethnography emerges. The study was designed to elicit the thoughts and beliefs from donors about the world of the modern-day blood donor. I purposively excluded interviewing non-donors as I wanted to concentrate on the depth of my donors' narratives rather than the differences in the narratives of non-donors and donors. I wanted to capture all types of donors, novice and experienced. Moreover, I had no access to non-donors unless they accompanied a donor to the session. The profile of informants at my session locale is not dissimilar to the wider profile of countrywide donors (NHSBT, 2006) in that there were more women than men and that median age was the fifties. Despite the limitations imposed on me asking for personal details about gender, age and ethnicity, I managed to get details from the majority about age and gender. My study group age range was 16 to 68 years old with a larger and more even spread of males aged from 16 to 67, whereas female respondents were clustered around early 40s with few younger donors, just one female respondent aged 18 and then the next youngest was 23. There were 34 male and 46 female direct

respondents, although evidence and inferences have been drawn from wider observation and field notes. Not all donors put down their age or gender; however, I annotated the field notes with gender and approximate ages of the donors who sat at the table with me via the process of observing and making notes as we talked. All the donors were white, and in fact in the later field notes the lack of minority ethnic participants was an issue for me and plans were made to attend a different session, but the difficulties described earlier made it difficult to arrange. At the 2001 census the town was listed as comprising 95% white population (CENSUS, 2001). However, as the thesis was being written, the lack of donors from minority ethnic groups was high on the agenda throughout on the NHSBT, and therefore my sessions were not unrepresentative. The NHSBT VIP appeal is trying to address this issue; by using the initials VIP, the NHSBT are trying to convey the importance attached to improving donors from minority ethnic groups.<sup>17</sup>

More interviews were recorded at the start and the end of the project, illustrating the personal difficulties which occurred at the interim and the repeat attendance of the donors whom I had already interviewed. The number of sessions averaged out over the timescale of the project to four or five a year. The attendance was dictated by three main factors: access, my availability and the date of the session.

I had actively located myself in a place where, through purposeful sampling, I would meet donors and see the action of giving blood as it occurred rather than ask a randomly

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<sup>17</sup> [www.blood.co.uk/vip/](http://www.blood.co.uk/vip/)



selected group of people about blood and its donation after the event. The rationale for this was that I wanted them to have recently experienced the actual physical event and feelings associated with their giving of blood, i.e. I wanted active participants in the donation process, to satisfy issues surrounding veracity and purposeful sampling. As I had no control over who would be arriving at the table or who would agree to contribute, the sample is random.

The women donors were in the main well spoken and articulate as can be observed by the language they used to describe their reasons for giving blood. The men were a wider cross section of society than the women. They were mostly from manual occupations or occupations such as the police, tree surgery, scouts, local offices and light industry at the local industrial estate. The women were housewives, teachers, hairdressers, local shop workers and some were from the doctors' surgery and library.

There was a large range of difference in the number of times the respondents had donated blood. The period of time that my donors had been blood donors for ranged from first timers, to those who had donated regularly for 18 years up to 45 years. Some of the respondents had donated intermittently, citing pregnancy, travel, illness and deferral as reasons for stopping.

There were differences in donating behaviour between the genders; for example, more short-term donors were men presenting themselves as a result of needing a blood transfusion because of an accident in the past, whereas the women were more often presenting themselves as a way of family tradition. An additional difference, on analysis, was in how they approached me. The men noticed me before they arrived at the table and were straight to the point in whether they wanted to take part in my

research; they either said no or were able to fill in the data sheet and talk to me at the same time. The women seemed not to have noticed me and once they saw my visitor badge they required the full introduction and were more hesitant in responding by talking.

This difference affected the quality of interaction at the table, because I was aware that the men wanted to do lots of talking but the women would have talked more in a different setting. On reflection, I would perhaps have got more in-depth personal data from the women on a one-to-one interview basis. As highlighted earlier, the permission granted did not include asking if respondents wished to see me in a quiet room to facilitate talking one to one. The hall was not set up for this and the tea lady would have had to facilitate this by reminding the donors to go for an interview after they had recovered. On the other hand, the depth of personal data revealed by the donors was surprising. This was both in the quality of the written responses and the verbal replies. The other benefit to table-wide interviewing was that it sometimes gave rise to a “round table” discussion. This was not something the recovery table was designed for; I got the impression that the tea lady thought that it was causing trouble to have the people talking at the table, as it could cause a backlog in the stream of donors requiring refreshment or could be the cause of a disruptive level of noise, or worse cause disagreements between the table members. The tea lady was good at monitoring how many she could fit at the table, and it seemed that people generally knew when to vacate their spot as no one was ever left standing. I felt guilty taking a seat at times.

Some people were annoyed, I could tell from their body language, at being left out of the discussion or the interviews, but (as reported earlier) sometimes I was overwhelmed by the fast pace of the table membership and the amount that people wanted to say.

The number of donors attending the sessions I observed was relatively stable over the duration of the study, at around 30 donors in the hall where the blood was taken over the time period I attended, and this was the same at both morning and evening sessions. I was unable to attract more respondents as the donors were split up into different locations; some were waiting to be seen, some were being assessed, some were waiting to donate, some were donating and some were recovering. On reflection, I think that where I sat was the optimal position to talk to the donors after the donation was done, which is why the quality of my data is so rich.

#### **4.8 The donors and me**

As Busby (2004; 2006) in research on hospital-based blood donors donating blood for genetic research has similarly described, the start of the relationship with blood began after negotiating a field site. The problems she describes in her research were not that dissimilar to my access described below, although I was unaware of her research at the time of my project as it was an unpublished doctoral thesis. Therefore, although a similarity exists, there are differences. Unlike hers, my session fieldwork was not at the regional centre, but at a church hall described earlier. Moreover, for Busby there was little control over the field, but mine was a living working field and as such it was subject to dynamics; people were asked to fill out questionnaires and they were keen to get their story told, as one said: *No one has ever asked me anything about it before.*

Titmuss (1997:178) noted that in essence there was a paucity of data on donors' characteristics, largely due to the fact that at his time of writing the possibility of a shortage was not considered; but he argued, despite collected hard data, the voice of the donor was required to allow understanding of blood donating as a form of social redistribution.

Some donors spoke only, some only wrote, but most were in a rush to get back to real life. The time factor became a big issue for me the more interaction I had with donors. I was aware of the amount of information some people wanted to give me and I received offers to re-interview many of the donors afterwards, but I did not pursue this due to reasons of personal safety over the location of where these interviews could have taken place.

Sanjek (1990a cited in Atkinson et al., 2007:361) reflected that until recently there was a distinction between describing what was observed and the feelings of the observer, ending up with the writer's feelings about events being relegated to field diary and jotted notes. However, the importance of the impact and the physical presence of the researcher are becoming of increasing importance. This is because the researcher's feelings about the "field" are important in that they mediate what they see, write down and, especially, what they may leave out (Atkinson, 2007:361).

Goffman (1990:125) argues that the truly immersed fieldworker is one who subjects themselves, both their body and personality, in order to penetrate the social situation involved. As described earlier, the blood transfusion sessions were run by a new person and a different set of donor helpers each visit. This added to the difficulties in

penetrating the back-stage life of the sessions, because the field had to be effectively renegotiated each visit.

On reflection, therefore, some commentary is now required about my physical presence in the field since time has elapsed from the start of the research. Coffey's (1999) work on examining the physical presence of the researcher has compelled me to evaluate myself in the field much more than I would have envisaged at the start of the project. My own thoughts about blood, blood donation, and the emergence of a bio products market as a section of the NHSBT have altered my ideas and perceptions about blood. Another aspect is that my own identity as a researcher has required me, of course, to reflect on my own status as a non-donor.

Coffey (1999:60) had examined the body in the actual process of fieldwork, which is pertinent to this part of the study. If I had given my body literally in the form of blood I would have gained immediate entry into the sessions, both with the staff and the donors themselves. She argues that ethnographers experience fieldwork as embodied social actors. The physical subject of my field was an actual body part, so I could and should have used my body to have started the process of fieldwork.

This led to reflection linked to the following issues in relation to the reliability of my data. I think that I relied on my identity as an academic more than as a nurse at first. I hid behind the questions and little data rolled in, but once I understood how the recovery table operated I knew when to approach the donor, and then the data quality changed and the amount was, at times, too much.

Due to the length of time of the project I eventually became a familiar person to some of the people in the field, and thus this caused me to question whether I repaid the trust the field showed to me in accommodating my sporadic arrival and facilitating my sitting at various places in the hall. However, as Emerson et al. (1995:3) remind us, the presence of the researcher always has repercussions for the social interactions therein. However, it is the continued presence which allows meanings to be drawn from the social actions and interactions witnessed. As such, therefore, my project did allow for the meanings attached to blood donation to emerge as a result of the continued presence in the same session site.

I made my first write-up of the research available to the research nurse. The staff on the sessions did not want to read it. Some of the donors wanted to know what would happen to the information after I had finished the project. I suggested to them that the finished project would be made available for publication in journals.

It was difficult to explain to the donors and, especially, the nursing staff what I was looking for by the taking of such a passive stance. The interviews and my interviewing style perplexed some of the donors as well as the staff; they did not know what I got out of “just being there”, as one put it to me. Furthermore, the process of observing and looking unnerved some donors and some reception staff. Stephanie, who I interviewed in 2005, thought I was: *mad to want to just sit there. Just sit there? Is that all?*

It is difficult to compose what was observed without missing something, which is why my project became spread over a long period of time. I could record and verify themes and behaviours as they reoccurred at intervals over time. They also had expected my interviews to be both longer and more directive. This displayed their only other

previous, rather stereotypical, experience of “being interviewed”, i.e. being interviewed in a quantitative style and being observed. This may be regarded as a typical reaction to ethnography in industrial societies, and I had experienced this sort of scepticism in other research activity.

#### **4.9 Staff and key informants**

This ethnography is not concerned with the NHSBT staff; however, it is pertinent to include a description of my relation to them as it affected my capacity to gather data. The role of informants is vital in any ethnographic research; as Ellen (1984:223) remarks, they provide an “authoritative voice”. A further difficulty that I had not expected was that the staff who work for the NHSBT cover a very large area and are rotated through the centres. This meant that there would be large gaps between seeing a friendly face. Indeed, in my field diary I had recorded the head nurse on duty saying she had: *done 85 miles today and two small children to get back to*. The time of this statement was recorded as 18.40 p.m.! More important to me was that this would mean difficulties in securing a chief informant. This aspect was a very important weakness in the subsequent visits, as for a few visits to the sessions it was very difficult to gather data because no one would talk to me. On one occasion, after a long gap between fieldwork sessions, I was not allowed in as there was no one at all who recognised me, despite me having phoned the research nurse prior to the session as arranged. It was very important to me that this would mean difficulties in securing a chief informant. Spradley (1980) has argued the paramount status of the chief informant, and I was downhearted at the prospect of having to develop a rapport with a new head nurse at

each visit. Not having a chief informant who would be the key to expanding the informant base as well as act as a source of triangulation was the first major setback. However, as time went on and I became familiar with the organisation's working pattern, the dismay I had recorded was largely unfounded because ultimately it is you, and "not you in the field", that matters. In the field notes I have recorded: *I need to seek a replacement but am unsure if the reception staff rotates. Try to gain permission to sit with her next time. Feel hopeless, should have been more organised. How can I have expected to just walk in?*

The reception staff led me through to the back-stage area where I was introduced to the manager of the session. Sue was the only registered nurse in the team that day. I was intrigued, as I had thought that qualified nurses took all the blood from donors. I knew immediately that I had a lot to learn and that my first mistake in the rush to start researching was that I had no organisational understanding of the NHSBT. I communicated this to Sue who informed me that this was a popular misconception which was linked to "the old days", when in fact first doctors and later nurses were the only personnel who took blood.

Sue was interested in my study, as she had been with the Service for a long time and had seen many changes. I really wanted to talk to her, but she was the point of decision-making in the session, and in the five minutes of our conversation we were disturbed several times by donor helpers seeking clarification of the deferment of suitability of a client. We arranged to make time to sit and have a coffee and chat later.

She told me that Bob (the research nurse with whom I had made my initial contact) had in fact emailed some information about me arriving to observe donation and therefore



she was “okay” with my being there. She suggested that I sat in the tea table area, as it was: *nowhere near the blood taking and also away from the equipment*. I had not disclosed to her the fact that I had spent some years as a nurse, as I felt that this information would preclude her giving me a full description of the processes I hoped to observe. It could have also prevented those nurses working as donor helpers from forming a relationship of trust with me, as they may have misunderstood the focus and purpose of my reasons for being in their place of work. For example, in one session in 2006, as I introduced myself to yet another set of donor helpers and went through the now laborious process of saying who I was and what I was doing, one of the helpers said to me that she was – and in fact it was always female staff – not able to do any studying. This led me to a conversation later on with the head donor helper, whom I had become familiar with, about the training of staff. She said that my being there was making the staff think about the training they get. This was worrying, as I had no authority to talk to anyone about anything except how and why they gave blood. This is illustrative of the dichotomy of the longitudinal researcher, as well as those who sit and watch, in that you eventually become the person people confide in. This is a positive aspect of my study, since it demonstrated to me that trust and camaraderie had developed.

I was given a badge with the word “visitor” and the date on it. Despite the fact that I should have been given a new badge for every visit, after a while no one bothered with the badge and in fact I wore the same one throughout. This was a symbol of the not only the longevity of my involvement, but also the developing immersion into my field.

I sat at the table feeling very anxious and was nervous as the first donors arrived at the table to “recover”. The tea lady was unsure of my level of importance, so she ignored me and did not offer me a cup of tea but said I could help myself to one as she was “there for the donors”. I felt by this that I was, of course, still an interloper and not a participant. Therefore, in the process of donation the role for me was clear: to wait and watch. However, the importance of the tea lady became apparent to me after a few visits, since she was the person who could sanction my presence at the table by the way she behaved towards me. As I realised this I began to feel more able to take control of the field, and the quality of my interviews improved.

As it happened, the person who made the difference to the project was the “tea lady”. Her role was pivotal in the whole donation process; it was she who bound the whole action together. She thanked the donors with a cup of tea and monitored their recovery, and she liaised with the other staff to “keep the table running”, as she called it. She also helped deal with queries concerning when the next session would be, and of course she monitored my movements at first. She was the only stable member of the centre I attended. A further person was the research nurse whom I had to contact before each visit. During the time of the project the position was held by three different nurses. Their role was essential because the staff on duty at the church was never really the same, and having her forewarn the lead nurse on the day made an enormous difference to how I was treated once inside and in turn my confidence in sitting at the table.

Observing the process of blood donation produced a different understanding of the process to that which was verbalised. This is an example of Malinowski’s layering, which became a vital tool to me as the data was reread to elicit themes and meanings.

Layering is a technique which added to my ability to see more in the field setting than I had first thought. The following is a fieldwork extract of my notes of the first time I watched a session:

They all look a bit anxious before they go to the trolley, clutching a piece of paper (the appointment time). It reminds me of outpatients in hospital. The person is quite deferential to the donor helper and acts like a patient. They do not have eye contact with anyone else; some wince at the feel of the needle going in, some watch the whole thing, some read, some actually look ill and a little pale. They look a little vulnerable up there on the trolley in full view of people they don't know. What if they do feel ill?

I was concerned about the lonely and vulnerable bearing which the donors had, like it was a laborious task they had to undergo and that it took a lot of mental preparation. However, as described later on, some who did say how they felt afterwards said it was nothing, just a thing they had to do. This may be an example of the layers of observation and experiences in that I saw one presentation (and the donors reported that they felt entirely different). This is not to say that all donors found the procedure "fine"; several were a bit giddy and all felt the need to eat and drink the refreshment offered afterwards. In contrast, the written accounts of donors were in opposition at times to what I saw. The written accounts described a mundane process, a functional rather than emotional activity. The most important aspect of blood donation is that it seemed to me to be an onerous task which was etched on the faces and communicated via the body language of the donors. The process is a verbal, written and finally a physical activity: there must be something significant which makes one person become a blood donor.

Further influence was derived out of Blumer's (1969) seminal view of ethnography as consisting of three themes. Firstly, humans are active, interpreting and reflective within

their interaction with others, creating their social self. The people who came to donate or who were “donors” did create a temporary or liminal self, what I call a “donor self”. This was a self that was revealed during the interactive process with me, and was created by the screening and the actual draining of the blood. The temporary self was also created through the presence at the recovery table. The temporary identity was dissolved as soon as the tea was finished and the donor went back to their non-donor life. The donors were not active in their interpretation of themselves as donors, as there was no time allowed for this.

Secondly, Blumer argued that one’s research must result in “intimate familiarity” with the subject studied. As a result of the long period of time through which I was involved in the donation sessions, I was very familiar with the process and more importantly, the lived experience of the donor.

Thirdly, Blumer argued that ethnography should add to and not distract from the individual. These thoughts were relevant to this contemporary ethnography, especially with regards to the second theme; attaining intimate familiarity with your selected group is very difficult, and may be dependent, in the end, on the bona fide nature of your enquiry as no one gives anything for free (Laidlow, 2000).

These ideas have some resonance for the findings of my research, as discussed later on in this chapter, in that during the process of my ethnography there was a change noted in some participants. They recorded and verbalised their opinions that, until I had asked them, they had not been reflective about themselves as a donor, or indeed about what blood as a body part meant either to them or to the wider society.

A further aspect considered was that, for the most true-to-life interpreting and reporting of feelings about giving part of your body, it was vital to be involved in the actual place where the giving took place. This is the rationale for locating my fieldwork within donor sessions rather than interviewing those people who give blood in other venues. It is relevant to observe blood donation in situ, as it is within the theatre or drama of “giving” where the truest story of giving blood may be witnessed. As soon as the donor takes leave of the donor session, they revert to the normal person. As a contrast, interviewing people outside of the “natural habitat” of giving did provide differences in the data collected.

An example of the importance of location and how it can affect the data is illustrated by the interviews of Sheila and Peter, who were both blood donors, but the contact and interviews took place outside the blood donor sessions, these accounts of their feelings about donation are different to the majority in their content and emotion. This illustrates that the best evidence is gathered within the place of action, although extra nuances can be identified outside the field. These can also be used to reinforce main findings.

A further beneficial aspect to encountering donors at the blood donor mobile setting was to meet them in what could be regarded as the “natural” or traditional setting to allow the archetypal or even stereotypical nuances to emerge or not. I did not find a stereotypical presentation of the self as donor. It was through the long time scope that the individual motivational forces for donating blood were revealed.

Therefore, despite the subsequent establishment of permanent sites attached to hospitals as the project progressed, I decided to continue my research in the mobile settings. The narrative is different to the data gleaned by Busby (2004, unpublished thesis) in her

study, and this could be due to the clinical or quasi-medical overtones of the hospital-based permanent site where she interviewed some of her respondents who were blood donors at the hospital-based genetic research clinic.

Therefore, what I have done is to turn my written and observed evidence into text, conveying a representation of the people and culture of blood giving in modern South East England. Whether this can be extrapolated out to the wider UK geography is a possibility for further research in a demographically different set of centres.

#### **4.10 Transcription, themes and the way forward: Making the thread**

This section provides examples of the fieldwork in order to convey the process and substance of my experiences in the field site. It also provides discussion on the process of turning my data into text and provides rationale for the scope of the subsequent chapters which emerged directly out of the data and field observations. I want to start by providing evidence from the field, as this adds to the veracity of the findings and illustrates the richness of the site itself as a base for future additional research.

The process of recruiting respondents and observing, writing notes down, observing the donation hall and the individuals involved was a complex task. However, after the fieldwork time had ended, it was vital that I had recorded as much in notes and annotations, especially concerning the emotions and mood of the donors.

Bryman (1988) and Kirk and Miller (1986) support the benefits of using field notes in the presentation of ethnography; however, they also highlight their limitations

especially on how field notes were recorded and in what context (Silverman, 2001:227). Polit and Beck (2008) argue that the variety of ways in which field notes can contribute to creating in-depth data requires constructive and regular transcribing. This was a feature of my data collection; it was imperative after each session to construct a narrative of what had happened and whom I had met, as the field was a live arena in a way. Pre-empting this criticism of the qualitative nature of ethnography, Spradley (1979) suggested that ethnographers keep four separate sets of notes. At the outset this seemed too arduous, but his list consisting of short note taking at the time, expanded notes made as soon as possible after the field session, the keeping of a field journal and a provisional running record of analysis and initial ideas about interpretation is in effect the workload of every ethnographer.

The keeping of a field diary to record problems and ideas helped me, as there were lengthy lapses in attendance in the field due to other commitments. A running summary record of gathering themes in note form improved the development of my relationship with the field, as I could direct the focus of what I wanted to hear and see.

Reflecting on these initial experiences was essential in my creating a fieldwork diary (notepad), and after each session I would sit in the car and consolidate the experiences and collate and date the interviews and experiences I had had.

As a result, my ethnographic record consists of field notes, both those written in the field and those in their later expanded form. Artefacts such as my visitor badges and the letter of introduction from the NHSBT were also very important together with the official literature given out to donors by the staff at the field sessions. They conferred on me a sort of authority to be there; the red file with the blood donor logo and

information and registration sheets were evidence of my veracity as a researcher. The badge was an object of my neutrality as neither a donor nor a worker.

This level of participant observation was that of passive (Spradley, 1980) in that I was engaged in the scene but not in the active form. Despite the limitations, most ethnography starts from this premise. I recorded in my diary that I felt dishonest; taking something for nothing. I had felt like this in earlier participant observation that I had carried out with a group of new mothers (Mahon-Daly and Andrews, 2002), and Ellen (1984) reminds us of the centrality of exchange in information seeking and gathering. As I was not a donor, I realised that I had little to exchange, except perhaps my stories from the Accident and Emergency room from when I worked as a nurse.

My field notes record: *In order to make any progress in the participant nature of my observation, I really need to be “someone” in the structure. I need to do one of two things – be a helper like the tea lady, or act as a nurse and take part in the bedside activity.*

The activity at the table was at first a little strained as people were unsure of whom I was. Some donors actively asked: *Do you work for the Blood Service? Are you one [donor] too?* My answer to both of these questions was “no”, and then I was asked: *Why are you here?*

I noticed that the donors never interacted with each other. There was no feeling of camaraderie at the table, and the body language of the donors was not expansive; they averted their eyes and concentrated on the refreshments in virtual silence. I reflected



that at least I was in situ, and I noted in my field notes: *I need to ascertain whether the table is always silent, or is it because of me?*

I have selected these excerpts to illustrate the trajectory as experienced by me as a researcher, and also to show how the long period of time spent gathering information revealed aspects of blood and the process of gathering blood to me that would not have become visible from a shorter duration of research. They also charted my progress from a stranger to almost a recovery tea table member. They reveal that have I gathered the embedded thoughts from the interaction displayed in the field, by relating to staff and by re-interviewing the donors, and demonstrate that a trust emerged between me and the staff and donors who recognise me, thus adding to the veracity of my findings.

At the end of the fieldwork period in early 2008, the range of information needed careful management to maximise the possible depth of meanings gathered. I refreshed my literature search and began organising the way forward.

I chose to transcribe each interview verbatim to maximise the relationship between the fieldwork diaries and the data from the questionnaires. The details on each sheet were typed up with key words italicised for easy insertion into the main text. Anything that I had written was typed; data such as the date, day, time, and observations such as gestures and tone of voice, for example. I put the questionnaires in date order first, then gender, then age (where the donor had revealed their age) and I then highlighted each for recurring themes. This process was laborious but was pivotal in the end for releasing the interpretations from the data in such detail. In this process I moved from a position of thinking that I had no data to one where I realised I had gathered a substantial

amount. The initial stage interviews carried out in 2004 were reviewed to track emerging themes and kept to be referred back to.

The words, either written or said by the respondents, were left verbatim, as any editing during transcription could remove the individuality or emphasis that was evident at the time of the interview; therefore every answer was typed up as it appeared on the paper and the respondent was allocated a pseudonym and an ID number.

The typing up of both field notes and annotations made on the questionnaires needed careful contextualisation, therefore dating and recording of vital observations such as tone of voice, other donors' or participants' proximity, time of year and time of day added to this first-time process of analysis, which provided an opportunity to identify any ideas for further analysis (Hammersley and Atkinson, 1995). As the number of participants grew, the importance of comments made within the field notes provided valuable data pertaining to contextual aspects, especially the growth of myself as a researcher and in particular the relevance of the project itself (Agar, 1986).

I also wanted to express the data in relation to those donors who would give and receive spare body parts as this was something many donors had written something about and as a result coding for body parts was added.

I was anxious not to have serious data inferred as anecdote. Silverman (2001) and Fielding and Fielding (1986) warn that there is a tendency for the analysis of qualitative interview data to become anecdotal, and they therefore highlight the importance of establishing a structure to the analysis. The formation of my thesis and its thread through the chapters is created by selected extracts which were theoretically relevant to

the aim of the thesis. These from the data as gathered, and this process was informed by both Agar (1986) and Denzin and Lincoln (1994) who cite theme analysis and extract presentation as a method rather than a weakness in methodology. Extract presentation is useful to convey mood and emotions, which can reverberate through the general testimonies. Emerson (1995:170) argues that such processes as described above are integral to creating an ethnographic account that is thematically organised but is presented in a narrative tale, which enhances the whole experience for both the expert and the wider outside audience.

#### **4.11 Theme identification and coding**

Kvale's (1996 cited in Atkinson, 2007:373) concept of the interview as a form of interaction worked well for my understanding of the stages of analysis. This seven-stage model includes thematising as the first stage. He argues that the process of thematising involves the researcher thinking through the goals of the project and then actively planning, using pre-knowledge to aid directional issues of the project. Within the development of this particular project the need to pre-analyse the inundation of data required this early theme analysis, which in turn allowed the most to be made of ongoing sessions despite the difficulties or vagaries described above.

Typing up and coding and classifying of the field notes, interviews and observations made me reflect the themes which were representative of the contributors' feelings, beliefs and behaviour during the session. A group of keywords was created; these were "body", "self", "risk", "special", "gift", "ableness", "getting back" and "bank". These were used to find accounts to create the emergent themes related to the future chapters.

Careful interpretation both of body and verbal language enabled the construction of my chapters as a result of reading, typing and rereading all the data. Once again, this task was time consuming and took longer than envisaged. The role of the supervisor was important here for I was struggling to keep fresh with data taken over such a long period. Rereading everything from the start to the end as well as at intervals allowed the real story of blood donors to emerge. Not all research can be constructed this way of course; however, this process definitely maximised the amount of data I used in this finished product.

Data from the observation sessions was sorted using the key words, coded for male or female and indexed in date and timing of session, in preparation for analysis and use in constructing the substantive chapters. Coding was created for gender with different colour stickers assigned to male or female. Inductive coding (Silverman, 1997:296) allowed the original codes' categories to be extended as the period of observation progressed. After analysis of the raw data, the most prominent themes were selected for reanalysis in the next phase of the project. This was related to the recurrence of these themes and keywords at later sessions. The keywords were "risk", "family", "body", "self" and "ableness". These early keywords were identified during the writing up of the written responses half way through the fieldwork. The talk from the table and the written accounts of the donors were divided into themes which then became the chapters of this thesis, with each theme being related to a known relevant theory to validate the truth of the findings.

The selected themes were related to the concepts or ideas of blood as a gift or a risk in society. The question of whether there had been a change in the reason for donation and

who the donor was donating for emerged from the analysis of the data. The impact of the technical body and how blood fits into the new NHS was another theme that was prominent and therefore informed the creation of a chapter. Blood as self was a theme donors introduced to me when describing how they could easily give blood as opposed to other organs, since it was not considered by them to be the main part of the self. Following more fieldwork and analysis of data, these ideas were confirmed as being the main areas for relating my research findings to theory as chapters in the thesis.

#### **4.12 Constraints, freedoms and limitations**

As I became immersed in the field the hesitancy and uncertainty of the staff and donors as to whether they should talk to me receded, and as a result my confidence grew.

This thesis gives the account of the events as I saw them, and not of the “native’s” perspective (Malinowski, 1922:25). I was free to see what emerged, even though it took me a long time to see it, rather than have the thesis deduced by the data. I think that one of the key areas of this research was that of the hierarchy of the self, which emerged directly out of the donors’ talking and reflecting about blood as a possible changed part of the self, and as a result is proof of the data as a valid record of the feelings and beliefs of contemporary blood donors.

Therefore, although I had no idea after the first few visits about where my search was going, and indeed in the field diary I recalled how I felt that there was going to be nothing to report and that it felt stupid and inappropriate being there, I now believe I have presented innovative data in the area of blood donation.

The process of accessing the field did impose limits and constraints on me. By this I mean that I was unable to have unfettered access to the field on an ad hoc basis. This had implications for how regularly I would be able to access the session to accommodate my teaching responsibilities. I was further limited in my ability to just turn up, as I had to remember to contact the research nurse prior to my arrival so that a message could be given to the staff on duty on that particular day. This was both a professional courtesy as well as one which protected the donors. Of course, this complex restriction meant that I did not always gain access, especially at short notice.

I did try to turn up unannounced on one occasion and this is what happened: I went into the hall and waited in the line to speak to the receptionist. She did recognise me and I said that I was hoping to do some research that day; however, the duty manager was someone whom I had never seen and she said that she had “better not take the risk” of just letting me in, as no one had told her about me. I was both pleased and frustrated. Pleased because it demonstrated that the donation site was a secure place for donors, and frustrated because it was another example of how complicated the field I had chosen was. It was also the period of time during which I had no supervisor because of illness, so I had no one to talk to about the difficulties. In the end I decided that I would telephone the research nurse from the waiting room and get her to give my details to the reception staff so that they could let me in.

This type of difficulty was a major factor which meant that it was too complicated and therefore not practical for me to utilise the opportunity I was given of gaining permission to interview throughout the region. It would have been too complicated to try to gain access at several mobile centres.

Also, by agreeing to sit at the table in the recovery area, I was also constrained in that I was unable to follow through a donor from arrival to leaving. It also meant that the registration table area was out of bounds to me.

On the other hand, as I became known to sessions, the recovery table became a source of rich observations and a very good vantage point from which to observe the interactions between all types of actors. I could see all the donating trolleys and the way in which the staff weaved their way around. I could see the interactions between the staff and the donors during the donating process and the bodily processes and rituals which were required to give blood; the clenching of the fist, the lying back and extending out of the arm, the turning away as the needle goes in. I could also see how congested the church hall got and how harassed the staff looked if they had more numbers than expected. I was also invisible, so to speak, as I sat with the donors and looked like one of them. This meant that people acted normally, providing me with a real-time image and experience of what it is like in blood donating settings.

Agar (1980:90) observed that with regard to the informal interview “everything is negotiable, the informants may criticize, correct, point out if the question is too sensitive, or answer in any way they want to.” This certainly became true in relation to my interaction with donors which concerned the donation of sperm. Spradley (1987) reminds us that informants’ views rarely coincide with those of the researchers’ and that when conflicting conditions actually cannot be met, then the researcher should not pursue the research. Campbell et al. (1979 cited in Hahn, 1999:304) highlighted that careful ethnographic research via participant observation is a means of producing

evidence which is culturally sensitive rather than relying on the size of samples as in quantitative research.

I had developed a rapport with one of the donors at the table. She told me that she was approaching 60 and had attended a record number of sessions for which she had received her pen and badges. She then read the questionnaire, and as the table discussion was about sperm donation and I recall her walking out saying: *This is not right*. Concurring with Agars' insight, I realised then that I had to tread carefully, as I was in danger of "losing the field".

The interviews were interviewee led, although open-ended probes were used to facilitate commentary from the group at the table. This was a fragile strategy as the table was not of fixed membership. The table was not a group at all and showed no interest in talking to each other at times. The remaining donors at the table after the lady left abruptly showed no allegiance or emotion. I recalled in the field notes that I would have to step back from the interviewing and be an observer from a role perspective, either of the donors or the tea lady.

A further example of losing the field was when someone whom I had interviewed in a previous session recognised me and said: *You're still doing this; thought you would have found what you wanted ages ago!* This dented my veracity in the ears of the donors sitting around me at the table in that session; what was the point of them investing their time and helping me if I could not finish the job? I responded that the first wave of interviews were so interesting that I had extended the period of investigation. Methodologically, the processes which have led to this thesis have been flawed in some ways; however, the truth was that the data took so much longer to



emerge that instead of the usual perception of quick quantitative research the concept of longitudinal ethnologies emerged, which is problematic both from the respondents' and researcher's perspectives.

### **4.13 Conclusion**

In Chapter 1, "Introduction", the purpose of the research was rationalised to be seeking evidence of the changes in donating blood in the British society, therefore the methodological approach and research design directly facilitated the quality of the findings in the thesis. This is due to the elongated period of time over which the research took place and the immersion of the researcher in the field. This chapter has provided detail and discussion of the processes involved in creating the field, and the experiences and reflections of how these experiences added to the data gathered. It discussed the pros and cons of the subject, field site, how the data was gathered and what the researcher found. The chapter debated the specific benefits to my project of the interpretive approach and how they relate to the data gathered over time. It reflected on the researcher in the field site and on the limitations and constraints. It provided detail and descriptions of who the donors were, where they were encountered and what interaction took place to produce the data for this ethnography. It has provided excerpts and field notes with the intention of transporting the reader to the research site. Finally, it examined the processes which occur in the writing up of the data, which turned the data into text and created the chapters which form the body of the thesis. The methodological approach adopted allowed the researcher to see at firsthand how modern-day donors approach their role as blood donor; it has also allowed verbatim

evidence concerning the rationale for giving blood and communicated the ambiance surrounding blood donation. The next chapter, Chapter 5 “From Gift to Risk: Challenging the Orthodoxy of Altruism”, is the natural starting point to present the data inducted from the theme analysis, as it represents the meeting of two major aspects of blood donation: that of blood being a gift and representing the changes in society, and blood being a symbolic of risk.

## **Chapter 5 From Gift to Risk: Challenging the Orthodoxy of Altruism**

### **5.1 Introduction**

This chapter argues that blood donation is seen not only as a gift, as exemplified in Titmuss' (1997) iconic *The Gift Relationship*, but also as a vector for risk, and further, that being a blood donor has developed connotations of active citizenship to manage this change (Petersen and Lupton, 2000:61). This chapter presents evidence from the data which supports this change: that blood has become imbued with both risk- and gift-related symbolism. It analyses the material from theoretical perspectives on risk; socio-cultural theory of risk and risk theory. I present an argument that symbolism and symbolic values associated with blood have altered over time in relation to social changes, as such attitudes towards blood and the language used to describe it can also be seen as barometers of social change in relation to risk. In the first instance, the chapter discusses risk theory to contextualise the data in relation to risk.

It refers to the risk society theories (Beck, 1992) as highlighted in the review of the literature and relates this to how the donors, as well as the NHSBT, seek to regulate the risk. One aspect of this new risk related discourse is the difficulties created by a new

aspect of blood donation, that of deferment or exclusion from donation due to being unsuitable. As discussed in the literature review, the deferment status carries connotations of potential negative citizenship, a risk for the donor who is no longer desired. This chapter links these risk ideas to concepts of citizenship which are developed throughout the subsequent chapters. The chapter explores another area which was derived out of the fieldwork, that of the risky body; some donors talked about whether the blood is at risk from the body and the persons' lifestyle. The chapter then explores how risks and risky groups challenge the accepted notion of blood donation being framed and understood as altruistic with an inherent and preconceived right to give.

This chapter therefore presents a new aspect to the altruistic paradigm examining this new "social indebtedness" of risk control associated with giving blood in a safe manner and how it is characterised by pre-understood behaviour patterns and characteristics of new blood donors in relation to contemporary connotations of safety and the management of the gift of donated blood as both risk and gift. It argues that blood donation can be seen as both a gift and a risk. Donated blood has become both a gift as well as a danger, as this chapter will illustrate, and as such the rationale for giving and the expectations of recipients have altered. Therefore, during my time in the field and as a result of reflecting on the early themes that emerged from my contact with people giving their blood, I argue that blood donating is at a turning point in its history. By this I mean that the received societal understanding of the giving of blood as being recognised as an uncomplicated gift has become mediated, as does everything, by the surrounding social milieu.

## **5.2 Altruism, gift exchange and risk in contemporary donation**

### **practice: From gift to risk**

In the past blood giving has been regarded as being a public display of altruism; however, it could now be regarded as part of a gift exchange cycle which involves the body and its constituent parts in society. In the risk society world not all bodies or blood are deemed to be risk free. It is in this way that the ideas of risk and risk perceptions and management are represented in the activity of citizenship by understanding that the blood donation pool cannot be limited and managed by altruistic control alone. The 2009 NHSBT annual report cited that it is dependent upon both the altruism and loyalty of donors to serve their customers, thus illustrating that the Blood Service is now a consumer-centred organisation. The conflicts between taking all blood offered and refusal of blood deemed risk carrying is the main thrust of the modern service. The blood donated enters the public domain and exchange systems to help those in need. As such only good blood must be not only given, but also offered.

The scandals about giving “good” blood away following its over-collection after terrorist attacks (Waldby and Mitchell, 2007; Schimdt, 2002), selling of blood to other countries, as well as the giving of infected blood to those in need were in the public arena as the research project commenced (Legge, 2000). The evidence presented in the media about tainted blood displaced the stereotype of the trustworthy volunteer and also

introduced discourse as to whether in fact donated blood is a gift or whether it is both a risk and a gift to those who receive it. The reporting by *The Guardian* (11 January 2008) that British soldiers had been given contaminated blood by the US was a recent example of the moral panics (Cohen, 2002; Garland, 2008) that have dogged the public image of the “gift of life” in recent years and affected the way donors feel about what the giving of their blood represents.<sup>18</sup> Thus, this revised exchange system creates bonds of bodily exchange rather than material, or animate exchange.

The new position in which blood has been located in society has a relationship with risk. Risk discourse is a powerful voice in contemporary public health (Earle et al., 2009; Petersen and Lupton, 2000). Seeing blood as risk-carrying, both in the actions of giving and receiving, is a new aspect in the gift relationship for investigation. As the project progressed, risks concerning public health and the services involved in their delivery were relevant concerns for the donors intermittently, either as an individual concern or as a population-level event (e.g. swine flu in the summer of 2009). Flower (2001:67–8 cited in Nettleton, 2006:65) highlights that a new process of managing public risk from selected groups is via the process of “othering”; this is a process whereby those deemed to be the source of risk are subjected to scrutiny and surveillance by those who are deemed not to be risky. This is evident in the way that blood donors are tolerant of extensive screening measures to exclude the risk groups.

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<sup>18</sup> [www.guardian.co.uk/uk/2008/jan/11/military.uknews4](http://www.guardian.co.uk/uk/2008/jan/11/military.uknews4)

During the course of NHSBT sessions I attended during the outbreaks of mad cow disease (Creutzfeldt–Jacob disease, a condition linked to bovine spongiform encephalopathy)<sup>19</sup> and later while reporting from the Archer Report (2008), the donors alluded at times to whatever the background controversy was concerned with, to which I responded in some sessions by suggesting that nothing was risk free. The Archer Report is the report on the independent public enquiry on NHS-supplied contaminated blood and blood products. The Archer Report's (2008:6) purpose was:

to investigate the circumstances surrounding the supply to patients of contaminated NHS blood products, its consequences for the haemophilia community and others afflicted, and to suggest further steps to address both their problems and needs and those of bereaved families.

The report was wide-ranging and evocative of how the recipients of the gift had been exposed to the risk without due protection. Despite its being freely available, not many of the respondents were aware of the report by name; however, actions from the moral panic ensuing from the scandals undoubtedly contributed to the changed behaviour and self-responsible gaze which donors have directed on themselves since 2008.

Some of the participants at this time in 2007 seemed to ignore any aspect of risk, others suggested that they knew what they were doing, referring to the NHSBT. Others had a list of risks and risky groups which needed management. These are described later in this chapter.

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<sup>19</sup> NHSBT statement on vCJD: [www.transfusionguidelines.org.uk/docs/pdfs/dl\\_ps\\_vcjd\\_2008-09.pdf](http://www.transfusionguidelines.org.uk/docs/pdfs/dl_ps_vcjd_2008-09.pdf)

The blood donor sessions, therefore, provided a fresh lens through which to interpret the actions and meanings of blood donation in relation to risk. Further, as my study was carried out over a long time period, there were differences in relation to the accounts of blood-related risk and riskiness at different times which were linked to background events, such as the impact of the media and global awareness of blood economies and blood-related catastrophes as referred to earlier in this chapter.

For example, the *raison d'être* of the original World Blood Day in 2004 was simply to thank the volunteer donors<sup>20</sup>. WBD 2004 was described as being dedicated to honouring voluntary blood donors for their priceless contribution to their communities (WHO, 2004). The strap line for the day was “blood: a gift for life”. Donors whom I encountered at the very start of the project recorded that their donation was similarly a “gift of life”. Those donors interviewed in 2004 said they give the gift of life to help others, for example Robin, a male donor, said: *I just do it to help others and it's simply a personal choice - just something I do.*

Rachael who worked in hospitals and had been a blood donor for 20 years said: *I give it to save lives for the benefit of others – it's a worthwhile thing to do and when I started everyone was pleased to help others out.*

By the end of the data collection sessions the gift of life was replaced by phrases like someone has to give it, not everyone can, not everyone is allowed to these days, etc.

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<sup>20</sup> [www2.doh.gov.ph/blood/dm51-04.pdf](http://www2.doh.gov.ph/blood/dm51-04.pdf)



These comments were indicative of how the risk factors related to blood changed over time.

The fieldwork brought to the foreground some areas for discussion related to blood and how donors perceive risks to be managed. Douglas (1996) asserts that risk is a cultural construct that is informed by culturally embedded assumptions and perceptions (Douglas, 1996:58), and that “once a source of safety, science and technology has become the source of risk” (Douglas, 2002). By this she meant that science had once excluded the risk but now has increased the danger and risk. Extrapolating this to risk-related issues of blood is useful in that we can identify when blood changed from being universally understood as a risk-free commodity to one heavily endowed with risk. This alteration could be argued to emanate from the recent scares and contaminations of blood since 2004.

A culture of trust and celebration of blood preceded this time (2004), and a culture of risk management replaced it as a result of the Archer Report in 2008. This means that the expectations of donated blood being managed “safely” were let down and donors now feel that they have to manage the risk themselves. Douglas (1996; 2002) argues that these types of shift are embedded in shared expectations and social function and responsibility. A further aspect, which is evidenced in excerpts from this study, is that as the risk quotient of blood rises there is also the politicisation of blood. Douglas argued that risk and accountability are related, because societies need to apportion blame as well as risk. Thus the population-level ownership of blood stock leads to population-level surveillance of it. The national blood authority is to blame for the risks of infections rather than the source of the infection, namely the donor.

The donors themselves were aware of this new capacity of the NHSBT, as illustrated by Connie who said of the NHSBT: *it is the only real way of knowing what goes on*, thus raising this issue that safety could only be guaranteed by microscopic or biochemical screening of the blood. The contamination of the blood pool by any one individual would be too much of a disaster so blood donation now needs management by both the self regulation of donors and by the NHSBT.

People involved in the giving of blood do not only depend on scientific knowledge to estimate and manage their understanding of risk, but myths and lay beliefs play their part also.

My Respondents varied in their opinions about risky blood which were commensurate with the background media coverage of blood-related scares, e.g. red meat. Outbreaks of mad cow disease in the mid-1990s created a greater risk from the donor to the recipient, and the recipient became more at risk in relation to infected blood in the factor 8 component supply. Some donors were aware that the risks relating to blood were liable to change, and many were pleased that the screening methods changed after each “new scandal”. The female respondents were more aware of the risks than the males. Male respondents were largely unaware of the scandals, with female respondents being more informed about background events. Risk to the blood supply was an overarching one and a second layer may be regarded as being from other more individual-related risks.

### 5.3 The “gaze” turned inward: Managing risk yourself

In the introduction to the thesis, I referred to how employing a Foucaudian perspective could enable understanding of the changes in blood donation, and it is from this perspective that it is argued that societal changes have led to the creation of a new “gaze”, and that the NHSBT could be argued as being a form of panoptic control. The new risk symbolism attached to blood, which I argue in the literature review has created a new “gaze” in relation to blood, was a change that was evident in the blood donation sessions I attended. The changes in management of safety issues in relation to blood can be seen to have been transferred to the blood donors themselves by applying Foucault’s (1980:155) notion of the individual gaze. As an extension of the medical gaze, Foucault articulated this as “an inspecting gaze which becomes introspective”. In time, he argued individuals, and to some extent populations, end up overseeing and surveying themselves. Webster (2002) believes that this gaze occurs at a public and collective level in the guise of public health strategies and agencies like the NHSBT. One respondent agreed, relaying to me her thoughts about the NHSBT being her safety net to keep her, and blood in general, safe. The public nature of donation allows the gaze to operate by the self-selection or de-selection of coming forward to donate. Some donors, such as Natalie who I interviewed in 2005, said about the risks: *They [the dangerous or infected ones] shouldn’t come. She used flu as an example: They shouldn’t turn up if they know there is a risk they will be turned down, you make your own judgement these days.*

The concept of the self-gaze can be applied to the activities of blood donors. The accounts later in the chapter illustrate that donors have turned the gaze upon themselves,

as well as others, in order to control the risks now associated with blood. The respondents did have a reflective gaze, reviewing themselves and others to keep well and safe enough to give. Sara, aged 40, said that she would give more often if she was healthy enough. Another donor, Estelle, said that people should only give their blood: *if they know it is safe and infection-free*. Bill, interviewed in 2007, said that he thought everyone should give blood: *but only if they are safe*. He was not talking about the blood being safe here, but referring to the person.

Greg, interviewed at the same time in 2007, did not believe that everyone can give blood. He said: *They [the NHSBT] are looking for people with integrity, who have no infectious diseases and are okay*. Integrity is related to truth, honesty and reliability; therefore donors who are only altruistic are no longer only what the Blood Service needs.

Peter, aged 58, who was donating in 2005, said that everyone should be tested: *to see if they are safe*. This was a new suggestion, and he felt that the low percentage of donors (he said it was 5%) would increase by this type of “include everyone and then exclude the risk” protocol. Colin, who was 51, said that he donated because it was the right thing to do, but he knew that he had to keep himself: *healthy enough to give*.

On the other hand Gary, who was 39 and was interviewed in 2005, said that blood donation should be compulsory; he was a bone marrow donor as well and said he gave blood because it was the right thing to do and a sort of social responsibility nowadays. By this he meant that nowadays you know all the risks that are carried in blood whereas before you could not always see them, thus making it a social responsibility for those whose blood was risk free to donate.

This relocation of blood from a gift to a risk management symbol became an area for examination in the data analysis. Aspects of interest, aside from the narrative and writings of my informants, come from the media. For example, the case below involved a recipient of a blood component who died, and on post mortem evidence of vCJD was found. This case was reported in the Guardian in 2009<sup>21</sup> and added to the exaggerated risk. In another recent story, those people with a history of a virus linked to chronic fatigue syndrome are being viewed as a potential risk to the blood pool and may be banned from giving blood.<sup>22</sup>

In this article, sufferers of a new viral infection, myalgic encephalitis (ME), are being potentially banned from becoming active blood donors. It is relevant to note the change of adjectives and language associated with the term “being excluded” changing to “being banned”. It labels a deviant aspect to those people suffering from a chronic viral disease on the same footing as those with negative lifestyle-related exclusion. These aspects are further developed in Chapter 6, “Deferment and Citizenship: Too Risky to Give”.

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<sup>21</sup> [www.guardian.co.uk/society/2009/feb/18/vcjd-infection-death](http://www.guardian.co.uk/society/2009/feb/18/vcjd-infection-death)

<sup>22</sup> [www.meassociation.org.uk/index.php?option=com\\_contentandview=articleandid=1250:new-zealand-moves-to-ban-blood-donation-by-people-with-meandcatid=30:newsandItemid=161](http://www.meassociation.org.uk/index.php?option=com_contentandview=articleandid=1250:new-zealand-moves-to-ban-blood-donation-by-people-with-meandcatid=30:newsandItemid=161)

The media acts to problematise the chance of risk, either real or perceived. The donation sessions seemed to be at a time void of any understanding of what was happening to blood in relation to risk and danger. At other times the united public understanding that, as one donor said: *we all need it*, allowed changes to the exclusion criteria to be absorbed within the process of donation largely unnoticed. Many donors felt it was their job only to give blood and then they would lose any control or ownership of it, or of who was barred from donating it.

Therefore, to compare and contrast the changes that this thesis asserts have occurred in blood donation, looking at Titmuss' respondents, the greatest risk then was the lack of truth-telling in the donor. Today the greatest risk is the failure of the NHSBT and other agencies involved, as well as the donors themselves, in the procurement of human blood to protect potential users from receiving damaged goods in the form of contaminated blood. The purpose of screening then, as understood by the donors themselves, is to exclude these sorts of risks, rather than in contrast the inclusion of as many people as possible, which was the case in the past. The process of screening acts to border the good blood from the bad blood, and therefore the good giver from the bad one.

Once again, by using the language of the World Blood Day referred to in the literature review, it is possible to chart the changing public perceptions and understandings of what personal qualities are required or expected of donors. In 2004, the premise of the WHO World Blood Day (WBD) was to simply express traditional feelings about blood giving. It was entitled "celebrating your gift of blood", and its purpose was to highlight true stories of people whose lives had been changed, and in many cases actually saved, by receiving donated blood. This portrayed the safe simplistic paradigm of interpreting

the gift exchange mechanism inherent in the UK at the time. This was evident in my data; some of my donors were donating blood as a form of celebration of the people whose lives had been saved. One male donor had had to have lots of transfusions so that his leg could be saved. As a result he was donating, not to give back, but to celebrate the fact that donated blood: *was there when I really needed it to save my life; if we all didn't donate then where would we be?* This illustrates another type of risk, that of the possibility of the blood stock running low, which for this donor was too risky. Another donor with a similar story, Andrew, had used up 12 pints, so he said he was there in case someone else was in as much need as he had been. The special qualities of being a donor were evident in some of the early accounts in the language used to describe why they could donate; they said: *Not everyone is able to*. This idea of “ableness” is related to citizenship as explored in the next chapter.

In a further deviation from the original WBD premise, the WHO in 2005 altered its slogan about blood donation from “blood saves lives” to “safe blood saves lives”, thus underlining the metamorphosis of blood from a sub-entity into an entity in its own right, with the concurrent issue of the blood supply to be kept safe to avoid its being a risk to others. Thus WBD 2005 argued that one should celebrate “the gift of blood” as opposed to “the gift of life”.

The idea that blood was a risky fluid, rather than solely a gift, was evident in a variety of accounts from donors. For example one of the respondents, Angela, carried a donor card for solid organ donation but had never been a regular blood donor. On reflection this surprised her, as she said she was unsure about the idea of compulsory blood or solid organ donation. She had some concerns about HIV and blood donation, saying: *I*

*feel slightly dodgy about needing blood due to HIV, but I suppose if it is life and death, who cares?*

I asked her what she meant by this. She said that she was unsettled about the risk of donated blood being contaminated with things such as HIV, but if she was in need of blood in an emergency she would take any consequences later. Anyway, she added, she was sure that the blood would be fine: *now that they are screening more and more people out*. She was relating back to the tighter controls which followed all the scandals (Archer Report, 2008).

Respondents of an older generation, for example Sue, who had donated for 30 years, seemed to respond differently to younger respondents to the question of how it felt to give blood, as well as what constituted a risk. This feature could be a facet of the medicalisation of younger society, who only sees the world through a medico-technical lens, and their innate trust of the whole process of giving blood has turned, according to many of them, what was once a selfless act, into one of mundaneness. In common with other older respondents, instead of giving a physiological response which was how the younger donors expressed their feeling, such as: *I feel fine*, this lady responded by saying: *I feel good that I might have helped someone, and anyway, only people who want to should donate*.

This account supported the argument, as presented in the Introduction Chapter 1 of this thesis, that the altruism which inspired earlier donors has in some way altered. Furthermore, this respondent felt that: *Not everyone should donate, not everyone has the right sort [of blood] and commitment. It is better just to take the ones that are really*



*safe rather than everyone.* Here, Sue is saying that it is the safest strategy not to trust everyone.

By commitment she meant to keep oneself in a “proper state” to donate. For her a proper state was what she called “clean living”. This argues that the donors and general public act as risk management themselves by creating the social milieu which inherently manages risks for society by creating a template or profile of who can or cannot donate or receive blood. Novas and Rose (2000 cited in Waldby and Mitchell, 2007:129) observed that the changes brought about by the importance of bodily investment to maximise the benefits of medical technologies meant that there was ever-increasing personal responsibility for risk aversion for the greater collective population-level health. This means that donors have to operate an individual approach to wellbeing and risk aversion (Rose, 2003 cited in Ericson and Doyle, 2003) to maximise their wellbeing; in effect surveillance is done by the donor or the potential donor themselves.

#### **5.4 Titmuss: From social habits to risk**

Titmuss’ seminal work about the gift relationship between blood donors and society requires further contextualisation in relation to the contemporary world and risk related to society. Titmuss postulated that the goodness of the gift is dependent in part on the honesty of the giver (1997:1127). The voluntary status of blood donation remains in the majority of countries (Coleman, 2004; WHO, 2010). However since Titmuss’ time of writing many more risks to blood have been identified. This mediates the premise of voluntary status to donate in the UK, because not everyone is free to acquire the status of blood donor, either socially or politically or, increasingly, bodily. Moreover, the

mode of transferring the gift from one person to another is less direct; in the early years of transfusion the blood taken was redistributed largely unchanged from the donor to the recipient (Waldby, 2006). Component production has led to a form of “processed blood” being refashioned from the donor’s gift. Inherent in this process are risks to both sides in the gift exchange cycle, because the gift is altered prior to its redistribution.

Evidence from my study is that the majority of respondents were unconcerned or uninformed about the “social life” of their body part after it had been donated, with the exception of younger respondents. For example, Huw (2007), an 18-year-old male student of Welsh origin, was on his first-ever donation session: *As to what happens to blood once it has left the body, I thought it went to be transfused; but it is broken down into products like platelets and plasma transfusions for special people with things like leukaemia.* He had read the leaflets, as it was his first visit, and looked unsure as he was aware no one else was as informed as he was. He explained that he had just taken his GCSE science exam.

Sue, an older donor, was not trustful of her fellow donors themselves, but put her trust concerning the safety of blood in the hands of what she and other donors still termed the NHSBT, and the might of the NHSBT and medico-technical surveillance: *I assume it is checked for usual stuff; you know, the sort of things they [NHSB] ask us about and check us for when we come in – I know that they check it again before they use it. I think I read somewhere that they check it again later – you know, to see if it’s still safe.* Sue did look concerned as if she should be checking up on the information she had read, and by doing so, checking up on the NHSBT. The eliciting of safety was rather naively left

to the volunteer to demonstrate by their willingness to open themselves to the scrutiny and the might of the NHSBT and medico-technical surveillance.

Titmuss (1997:171) stated that:

To obtain sufficient quantities of blood, in the required blood group proportions, at the required times and in the required place are not processes which can be determined and controlled by the medical profession, despite its power to decide who may and may not give and the destination of the gift.

This quote has acquired new meaning in relation to the procurement and use of blood. However, in it Titmuss was hinting at other social forces which contribute or mediate ideas about symbols in society. Blood in Titmuss' study was not fully symbolic as a risk to society. In the index of his book *Gift Relationship* there is no listing for "risk". However, in the chapter entitled "Is the gift a good one?" he does examine risks inherent in blood as it stood then, but it is clear that the concept of risk is not as clearly defined then as at present. With regards to risky donors, Titmuss (1997:201) talks about "social habits" as opposed to risky lifestyles and links these to poor education and lack of advantage. At the time the newly emergent Australian antigen which is only identifiable as a result of exposure to the hepatitis virus was the only accepted risk, and he argues that the patients did not ask whether the donated blood would actually infect them. With the background of what he called "consumer ignorance and uncertainty", trust was placed in the medical profession to manage the risks. Titmuss (1997:202) was more concerned with bad blood being received rather than being given to a recipient. He argues that then the patient has the right to truthfulness.

A further aspect from this quote has resonance today. In his words it is more of a risk to ensure that the required quantities and required blood group were available to the public. These concerns were indicative of the location of blood in society at this time. By this I mean that society's relationship to blood was concerned with logistics to move the blood where it was needed and medicalised preparation of blood into the only component available at the time: blood groups.

Due to lack of trade or "blood economies" at that time, more concern was given to how to move the whole blood that was collected around to those in need, with the safe transportation of blood of logistical concern. This was due to the short "shelf life" of blood. These issues have, with the growth of technology, largely now gone away. A central issue for blood safety at Titmuss' time was that blood donation operated the blood grouping system. This is evident in some of my research informants as illustrated by the testimony of one person I spoke to. Alan, 46, who had been a donor for 18 months and came regularly, said: *Once I was accepted even though I had a problem with jaundice in the past. I originally came with my wife who is also negative. So on account of me being O Negative, I thought it would be worthwhile as it is always needed.*

He was indicating that this blood group was "always needed", and as he was lucky enough to be one of the few who were that "type" he felt obliged to give. The way in which Alan readily agreed to all the tests to ensure that he was now "safe" to donate following a previous unspecified jaundice attack confirms the argument that blood donors, as well as the NBS, have a framework for ensuring safe blood. He said that his wife donated: *Once she was accepted as she was neg.* By using this slang "neg", Alan

was saying that his wife's blood group was negative. By this he was referring to the rhesus antigen status of the donor. This idea of blood groups being the most "needed" representation of blood is anachronistic, perhaps, as the technology of blood manufacturing can create all inherent parts of a blood group, and in fact hardly anyone at all receives whole blood in its donated form anyway (Starr, 2002). The older donors were concerned with their Rhesus factor status in a way which was different to the younger donors; this is another difference in donor behaviour across the generations. So for older donors there is a risk, but as the younger donors I met had no understanding about the sub-components of blood groups this did not represent a risk to them.

The tone of Titmuss' work transmitted a feeling of reverence for the donors who braved blood donating for the benefit of others; however, the tone of some donors was different. It was Alan who further commented that giving blood at the blood sessions was normalised with risks managed. But within this "ordinariness" some removal or assessment of risk is present, illustrated by his testimony: *They make it seem so ordinary, especially after you have been coming for a while and are trusted.* He added that by being trusted he meant that you answered all the questions truthfully, and after assessing that your blood "matched" your answers, so to speak, you were put into your blood donating routine.

Agnes was another respondent who engaged in this "risk management" behaviour. Agnes was an older respondent who had only donated her blood "about three times" but was enthusiastic about giving her point of view, which was that she did not think everyone should donate blood: *even if we all need it.* When asked about the risks attached to giving blood in the media she said: *The reasons why I give my blood is not a*

*lot of people do, you know, they are unsuitable, and because it's so easy and I have a blood group that is universal to everyone. Being a universal donor means that you have the blood group O Negative.*

When asked what that meant, Agnes showed that she was experienced in the jargon of blood donation, and that she still thought the need for human blood to be directly linked to blood groups. As she was a new donor, this perception of the importance of her “universal blood group” was in its native state. This concept is based on the “gift of life” paradigm, whereby what is given is received in the same form.

Other younger participants understood that their blood was taken to be turned into other “types of blood”; for example Huw, as quoted above, who understood that it was broken down into products like platelets and plasma transfusions, and did not only see blood groups or antigens.

Titmuss also highlighted risks being associated with or linked to time, “the right time”, hinting at the risk of not having the “gift” available at the right time. This also relates to the logistical management of blood or proportions of blood groups and of blood itself. This risk persists and has been amplified by the recent population events, for example viruses such as swine flu in the summer of 2009.<sup>23</sup>

Some of the respondents echoed worries about there not being enough blood, especially at special times such as Christmas and Easter. This is an extract from my field notes

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<sup>23</sup> [www.blood.co.uk/pdf/publications/donor\\_winter2009.pdf](http://www.blood.co.uk/pdf/publications/donor_winter2009.pdf)

which serves to illustrate the point here. The session was on a Tuesday before Christmas 2006. I had arranged to attend, as I wanted to see if there was a different atmosphere in what would be a traditional altruistic period. I also chose to sit in a different location within the church hall. I sat in the first waiting area in the newer hall adjacent to the initial screening booths. From here I observed the behaviour of a donor who was “not allowed” to donate and who was not happy. He had made a special effort to come to the session in the rain, he said, because he had a special blood type. The waiting room itself took a while to recover from this interchange. I observed that the waiting donors still did not discuss the incident. This donor had felt obliged to turn up to do what he described as his duty as a result of his special blood group and type. He had also turned up at Christmas time, as he felt that his blood would be needed even more than normal. This illustrates how he, as a donor, understood his part in managing the risk of running out of his type of blood, especially at the special times of the year.

Donors have always understood the social duties attached to being a blood donor. Titmuss described similar feelings of obligation in those donors who answered his questionnaire. His donors also felt that giving blood was a social duty, especially those who had rare blood types. Other respondents had continued donating blood as a result of social conscience during the Second World War (Titmuss, 1997:292–6). Therefore there are differences as well as similarities.

Titmuss (1997:83) hinted at what we now know to be true. He argued that the growth of scientific knowledge, and the “knowledge” about how to preserve and divide blood, would position blood and the transfusion service to an “indispensable and vital” part of modern medicine. I would argue further, that in essence the power of blood instead of

being imbued to society through ritual and religion is now held and distributed by biomedicine.

Titmuss did introduce the area of risk, although the greatest risk at the time to the sanctity of the Service was from a singular virus: hepatitis. Areas of blame were located in the wrong blood being donated by the wrong donors rather than any failure in the system. Titmuss realised that in fact the greatest risk factor to the safety of human blood was the donors themselves. The element of trust is a key issue and will be examined later in line with deferment issues.

Some donors were aware of the shelf life of blood – and it was this that propelled them to turn up regularly. Once again, there was a generational difference in this area with younger donors saying they knew that the body replenished its supply after three weeks and the older donors displaying concern for the blood degrading after three weeks. Concerns over logistics and distribution were not issues for this set of donors.

## **5.5 “Someone in need”**

A further strand to the risk symbolism portfolio carried by blood and its donation was voiced by the respondents. This was that the recipient had to be risk free as well as the donor. Jackie corroborated this idea that the donors want to see their gift not given to risky recipients, and as a result make a hierarchy of suitable risk-free recipients.

Jackie had previously been a donor until the year or so before having her fourth child, when it became too difficult to continue. But she said that she: *got back round to doing it as it is a good thing to do*. Her main motivation for giving blood was that as a healthy



person she thought she should help: *As a police officer's wife I know that donors are always needed.* She gave her blood in the hope that it would be received by: *someone in need – not a drunk or a drug user or anyone.* Thus she was reserving the giver's right to decide the recipient of her gift. Her blood was at risk of being given to a risk recipient who might abuse it.

When asked about those with blood disorders or past medical concerns that may preclude them donating, she felt that: *If you put people off too much no wonder there is never enough blood. It's a sort of balance, isn't it?* As she had spent time training as a nurse “a long time ago”, she said that maybe the Service could develop more technology to allow more people to be able to donate: *What actually has happened instead is that technology is used to exclude potential donors and rob them of their right to donate.*

Other accounts from the data about who the donor was not providing blood for included intravenous drug users, alcoholics and people, who, as one donor said, are just too selfish to even find out whether they can give. This donor said he could not believe that out of such a large population only 5% can give: *even with all the new restrictions.*

Agnes in 2006 said she did not think everyone should donate: *If there is a risk of infected blood then it shouldn't be passed on to people who have other things to fight.*

A further aspect to donation being at risk of being misused was highlighted by a few of the donors: the risk of their donation not being used for the right type of needy person.

Gail commented with regard to understanding what actually happened to her donated blood. She said: *Vaguely, that worries me now, actually. I should care with all the*

*technology these days. They [doctors] can do all sorts with it now.* Gail was hinting at the surveillance in place and the risk of loss of control of her gift. Earle et al. (2009) draw on both Foucault's (1977) and Armstrong's (1995) theories of the changes seen in relation to the "clinical gaze". These theories, as identified in the introductory chapter, enable reinterpretation of how blood donation is seen in relation to the new collective body. The clinical gaze has, it is argued here, begun to work in tandem with the growing requirement of donors to engage in self-surveillance and self-regulation in relation to their blood – in giving it, but also increasingly in understanding what happens to it after donation.

Connie summarised why she gave her blood: *Perhaps one day I will need some blood; I like to give something back to society. I was surprised when I read about what happens to the blood. I was surprised it was such a small percentage, I think 5 to 6%, that goes to accident victims – lower on the list than pregnant mothers. Top of the list was cancer victims and for testing.* By this she meant research and experiments. Connie was a little disappointed that her blood was not used for immediate use. Jackie, in her account, also was surprised at how little of the blood goes to immediate actual life-saving use, although she did say she was pleased it was going to a good cause, however it got there.

Waldby (2006:41) cites Martlew's (1997) research which argued that less than 5% of all transfusions were of whole blood highlighting that most donations were tailored to meet the clinical needs of individual conditions through the fractionation process described earlier in Chapter 2: "Historical Context – The Rationalisation of Blood: Blood as Science". These ever-increasing technological innovations have created a distance between the giver and the recipient. The accounts presented here conclude that donors

prefer that their life-giving donation does just that. The processed composite of blood parts which the donation turns into through this process, however, is remote from the giver, and this places strain on the gift relationship. Within the surveillance society, and in a consumerist society, expectations about what may happen to blood donations are a potential area for conflict.

Donors used language alluding to two aspects of the role of the NHSBT. The first one was in relation to trust and safety. Donors put their trust in the Service to keep the blood supply clean and safe. Thus the use of words like “trust”, “checking”, “checked out”, etc. to describe the policing role of the organisation. Another style of language was that of paternalism. The donor viewed the NHSBT as a controlling and supporting figure; for example, they used phrases like “the system”, “they”, “they told me”, “I trust them to tell me”, etc. This language still positions the donor as passive in the relationship, and the Service as active. There was some nostalgia related to the work of the Blood Service mainly by the older donors. They missed the intimacy and specialness that the feeling of giving gave you: *It's not the same now. Before you really knew you were doing something special. Now it is just a routine ... you go in and it is not even the same face.*

One lady, Pat, recalled the good old days; she was the tea lady who was too old to give any more, so she has decided to continue her association by performing the tea lady role. Pat's friend, who is still young enough (her words) to be an active donor got a big bruise from the letting: *Look at that – she held out her arm for a full inspection. Not the same now it is not a doctor. Don't think they [the donor helpers] know how to take it properly. In the old days you never got a bruise.* Her (also a tea lady) was “giving”, to

use their parlance at this session, and had turned a “funny colour” as she approached the tea table.

Pat said: *I have given all my life – starts from the war... I was in the ambulance service then. Everyone who could give knew they should – you trusted the doctor then to rule out the bad ones. In those days it was always a doctor. Today she (the person taking the blood) had been a bit rough: not used to veins in our age.*

Ideas about trustworthiness are not only based on who is giving it, it seems that the best trust is saved for doctors who are perceived to be the rightful managers of blood for the public. The issue of trust is vital to how we utilise modern-day blood donation as well as the management of blood donation.

## **5.6 Blood and risk portfolios**

Earlier in the literature review and in the earlier sections of this chapter, the relevance of risk theory has been applied to blood donation. In extending this, I refer to the concept of risk portfolio. Hacking (2003 cited in Erickson and Doyle, 2003) talks about the development of “risk portfolios” as an extension to the borders and pollution theories of Douglas (2002) and the risk society theory of Beck (1992), arguing that blood has developed its own portfolio of risks. By this Hacking means that some blood is worse than other types, and some people’s blood is more of a risk than others’. This section of the chapter relates the accounts of donors to this developing construct. Risks related to blood were not a feature of the narrative or interaction within the later sessions; the interviews taken at the start of the project reveal more concern for risk than the later ones. This correlates with the background moral panic attached to blood and body

snatching as a result of the blood infection scares at the time. The application of risk symbolism to blood was crystallised at this time and is illustrative of the ways in which moral panic theory is useful to see how areas in society are subjected to cycles of reorientation. Moral panic theory was highlighted in my introduction, and is defined by Cohen (1973) as “a recurring and ongoing preoccupation with the perceived threat to social stability posed by unregulated, undisciplined and disorderly youth outside of adult control.” We can apply this idea removing the word “youth” and relating it to the blood supply being destabilised through poor regulation and thus becoming imbued with risk symbolism.

For instance, one of my respondents, Jed’s conversation did not communicate the concern for risk at first, but when read later it seemed to. In reality he had become a donor because he needed to be involved in controlling the risk to blood from bad donors: *It is only my second donation.* He said that he decided to become a donor because he: *felt it to be a good civic duty. It feels as though I have done something to help those less fortunate than me. Although it should be part of a person’s individual choice, it is not like that really.*

In fact, Jed was acting out a safety measure by volunteering himself to donate as one of the special people who could donate due to the blood scandals at the time. He said: *It should be part of a national ID photo, a bit like on the driving licence. Not everyone, but perhaps those engaged in working for the civil service, police, military, etc. should be made to do it [donate].*

By this Jed was hinting at those in occupations which are perceived to be in some way checked out or safer than the ordinary people, and as a result their blood and lifestyle

was more trustworthy. This was something that occurs with frequency across the respondents.

Another respondent, Janice, who was interviewed in the very early stages of the study (2004) and could have been influenced by the extensive media reporting of the unethical use of body parts in a children's hospital, said: *I'm happy to donate any part of my body, so long as my donation isn't used in unethical research, like the one in the paper and on the TV.* Both this respondent and Jed's thoughts on this were echoed by the others at the table, who expressed trust that the NHSBT was unlikely to be involved in any scares of a similar nature. Jed was transmitting here his own concept of risk and how the Blood Service enables successful management of the risks as applied to blood; some types of people are not good enough to give and some are. According to Douglas (1996), it is only when a substance falls out of place that it becomes a risk. Blood became contaminated according to this theory when the boundaries controlling who could give became weakened and control was lost, resulting in serious consequences and infection of the people to whom blood donors donated to protect.

Henry, a 28-year-old whom I met in 2006, did not reveal the length of time he had been a donor. He did not feel that everyone could or should donate blood and said that around 10% of the UK population were regular blood donors. His reasons for why not everyone can give blood included their lifestyle, drugs, travel and illness. He felt it better to actively exclude the risky blood rather than have any contamination. He became a donor because he felt he was: *doing the right thing and being socially responsible; not everyone is these days.* This idea of donors acting in a more socially responsible way than others in the population is possibly a way of bordering good blood

from bad blood by ensuring that there is a constant supply of people who are healthy and safe enough to donate. It is also indicative of the way in which this fieldwork reveals dents in the orthodoxy of altruism. The infection of the actual blood supply system was fatal to the underlying public consciousness that donating blood was a good thing to do. The impact of the risk donors may both have or give engendered a change in perceptions about why people donate. In my study donors started to use different language from donation being a good thing to do to being an example of the right thing to do. Edna, aged 60, who had been a donor for 20 years, said that for her blood donation was now the right thing to do: *To contribute, you know, to wider society and it is something everyone should be encouraged to do to show they are involved.* In Edna's case donation is not an individual act of goodness, but a way to express or measure social involvedness and safety.

### **5.7 Risk from the body itself; tainted blood and blame**

This chapter is concerned with using data from my fieldwork to relate changes in blood and its donation in relation to risk, and it is constructive to relate these changes to the donors Titmuss described. He argued (1997:169) that blood from tainted donors whom he termed "skid row" donors would result in not only less blood, but also bad-quality blood. He argued that the authorities he spoke to in the US agreed that donors should enjoy a good diet to ensure good-quality blood. My research uncovered a new type of "skid row" donor; one who rather than being untruthful about the safeness of their blood let themselves become ill or knowingly did not keep themselves well enough to donate. For example, Nancy was a 35-year-old who had returned to what she called "active

donation” after what she termed as: *a long break, for many reasons*. She was castigating herself for not managing her body better to enable her to continue to donate, which she felt was the right thing to do. She had given blood regularly for a year since the break, but she did not elaborate on the reasons she had had for stopping. However, the answer to the written question concerning what had made her donate was that she: *saw the transfusion bus and realised that I was heavy enough to donate again. I decided to start it up again, give it a go, you know, now that I am heavier; I am well again now*.

This was, I inferred, a comment on the fact that she had not stopped giving as such, but rather was deferred due to her body mass index being too low to donate. This had provoked feelings of guilt that without her contribution there would be a risk of not having enough blood. She recorded that she felt that by returning to donating she was: *making some contribution to the community*. She was very reflective about this recent episode and, if she had been interviewed on a one-to-one basis, her testimony may have detailed this feeling of self blame in more depth.

As a result of analysing the accounts from the respondents, which relate to the changes in social perception and management of risk, a more pertinent question came to mind which could be related to the “from gift to risk” premise central to this chapter: can blood be at risk from the bodies from which it comes? And do people think that this is still the case today? Blood donation has become largely sanitised as a risky procedure due to its technicalisation during the actual processes of donating and redistribution. Although earlier respondents voiced safety concerns, I found that later respondents mainly described blood and risk in a new way: that of the body being a risk factor to blood itself. To illustrate this I draw on two respondents.



Sharon, 46, said: *I really understand the idea of risk and blood. I recently had to have an operation and I knew that I would lose blood, so I gave my own in advance! Yes – you know, what worries me the most is what they don't know is in your blood. They didn't know about all the stuff they've since found, did they? Like hepatitis B and C, never mind about HIV!*

Continuing on with her thoughts about blood and risk she went on to say: *Nowadays we know more about what we eat and drink and how it is used in the body. I don't think all the tests they do are nearly enough. I mean, who knows if they [donors] are telling the truth? I think that blood has become a big risk for us to monitor. In a way blood is what drives all the operations as you can't do an operation without blood.*

Elaine, 34, concurred with Sharon over the “you are what you eat” dilemma: *What I think is really odd is that they don't ask or care if you are a veggie. I mean, I couldn't bear knowing that a meat eater's blood was in me. If I had to have one now I would raise the issue. I want to know that it is healthy blood, if you know what I mean. I feel sick just thinking about it. I spend ages thinking about what I put into me, and if I had to have an emergency transfusion I would get all sorts of shit. Maybe they should ask about diet and alcohol as well. What about cholesterol – now I'm really into it!*

A further risk-related area which was talked about was that the donor themselves could be at risk from the whole process. Some respondents were phobic of needles and there was a risk of fainting. For example Queenie, 56, had given blood fifteen times even though she felt she might faint each time: *I do it to play my part in the community. I might be a blood receiver one day.* A further example was Julie who described herself as: *needlephobic*, but she still turned up despite this.

Stanley, 35, a long-time donor as he called himself, in 2008 talked about the importance of getting time off to do his “duty” as a donor. This was getting increasingly difficult, and he said he had had to combine his lunchtime with giving blood; he had been eating fish and chips, he said: *Shouldn't be eating that stuff – my mother would kill me eating this stuff before donating, it will put my triglycerides up! I love the whole process; I just watch it when I am here. I started when I was in the Territorial Army, and you need to have a really good reason not to!*

This section has exposed a new type of risk in relation to blood donation, that of the donor's body not being healthy enough and that the donor has a responsibility to moderate and optimise their diet in order for the blood to be of good quality.

## **5.8 Embodied risk**

The body and how blood is related to it is a further addition to the contemporary portfolio of risk of blood and blood donation. In the Chapter 3 Literature Review the rise of the body and the inherent embodiment of risk were discussed as a major concern in the literature. The fieldwork produced its own contribution to this aspect of modern blood donation, which is described in this section. This was an unexpected strand of data which came from the fieldwork. This type of risk became evident through the repeated rereading of the data, which revealed that donors were seeing a new risk in blood donation, that from the body itself, which I shall call “embodied risks” and I argue that it represents a new way of interpreting blood as a risk. The central argument of this theme is that the body and the self have become both potential and actual risks to blood. For example, donors described the relationship of their body to the capacity to be

or stay a donor; they said they were or had been too light, too heavy, too unhealthy, too promiscuous, and even in the case of one donor, homosexual. These are therefore lifestyle risks. Kavanagh and Broom (1998) identified risks which extend those concerned with environment and lifestyle, i.e. those that are located or embodied in the person, representing corporeal risk.

Embodied risks are embedded in or emanate from within the body. Language from the donors suggested that in the case of blood, for example, the body may have the wrong clotting time, too many cells, or too few red blood cells. The blood can be a carrier of a genetic disease or have high cholesterol, for example, so a person may be in fact at risk from their own blood. Therefore the risks from blood, it is argued, are in fact twofold, being either bad blood, or the more stereotypical risk, that of the wrong blood.

This is illustrated by donors understanding the inherent need for suitable blood. For example Betty, who had been a donor for 32 years as a result of needing blood during childbirth, reflected on the changes in the Service generally and felt that:

Safety of blood could be improved by making it a social responsibility to donate if your blood was suitable – you know, clean – nothing wrong in it and you are healthy. I don't know why they allow smokers to give; just think what stuff is in there. On the other hand, being made to donate is too strong a concept to be viable.

Bonnie had been donating blood for 18 months, and for her the management of her donation was done by the NHSBT. She felt that giving blood at the blood sessions was normal: *They make it seem so ordinary, really, when you have been coming regularly and they know you. They feel that you are a safe donor.*

Bonnie was referring to the NHSBT when she said *they*. She felt reassured that the process was checked and managed by the *transfusion service*. Her comment tells us that donors perhaps understand that trustworthiness takes time to build, and that donors have to attend regularly to be afforded this trust. Once again, this reflects the changed nature of blood donating today, as the message of blood donors being required to be regular rather than altruistic in their giving behaviour is the context of WBD themes as discussed earlier in this chapter.

A further risk which emerged from the research is that of the donated blood being misused. An example of this was the disposal of the huge quantities of donated blood after the post 9/11 blood donation surge (Waldby, 2007; Starr, 2002). The actual destination of the blood was kept secret in case it upset donors and stopped them re-donating in times of real need. The Red Cross had to throw it away because it could not manage such a huge amount, especially as the terrorist attacks resulted in fatalities and not casualties. A less sporadic risk voiced by respondents was the risk of the wrong people or type of people getting the benefit of the blood and generosity of others, as well as blood being used for what was deemed “unethical research”.

Within the contemporary risk theory Holloway and Jefferson (2000) remind us that perceptions of risk are filtered by other socialisation factors such as race and class and, especially in the case of blood, location. Blood supplies today are at their best-ever level of safeness, with some researchers reporting only a mathematical risk (Busch, 2003). This has been achieved by ever more restrictive donor eligibility and greater sensitive biotechnical screening methods. In the US, as testimony or underlining my thesis of disembodiment of blood, there are ever-growing numbers of products produced from

blood that are regulated via the Food and Drug Agency (US) with cellular products in particular having been added recently to this scrutiny. This is not to say that there will be no new risks, a view theorised by Sharon, one of my informants quoted above.

## **5.9 Risk and the “Blood Service”**

The risk discourse which surrounds public health is pertinent to blood in relation to its safeness as a social fluid and a public utility that is taken from one person and given to others. Risk management is related to the accounts of my respondents in the way in which the donors and general public relate to the body of the institution that provides blood (NHSBT). Healy (2006) argues that the trust which has previously been imbued in the body of the donor has now been transferred to the body of the NHSBT. Many donors and other respondents refer to the overseeing role of the NHSBT in the management risk for the rest of us. For example Inger, a 68-year-old female, revealed her views on keeping the blood supply as risk free as possible: *As a community we need to monitor communicable diseases. And as individuals we need to act responsibly, you know, what we eat, drink, and generally how we behave.* Moreover, Inger hinted at the risk of misuse of collected body parts: *No, there isn't anything I wouldn't think about donating; but it should be for medical reasons only, not purely cosmetic, except in cases of burns or other accidental disfigurement.*

Therefore Inger is expecting the NHSBT to manage her blood donation safely, not only in whom they allow to give, but also in who gets a donation from the pooled resource. It is also possible here to infer that inherent with safety are issues concerning prevailing

social values. This aspect is extended for discussion in Chapter 7: “Giving to Get Back: From Altruism to Covenant”.

Clive, interviewed in 2006, felt that the risk of the Blood Service having another scandal meant that: *Less and less [people] should be eligible due to restrictions, and this has made it more and more important for those who can to do so. It is quite a burden, especially if you don't feel well so can't donate when you are supposed to.*

This type of perceived risk to actual number of donors diminishing adds to the idea that blood is risky, with Clive further alluding to risk as it may apply to donors and not recipients: *Yes, I think that everyone should try to give blood – as long as it doesn't affect their health, make them ill.*

However, the meaning of this statement was unclear; for example, it might have been the case that Clive's perceived risk was in relation to how giving blood could impact the health of the donor. Moreover, by saying not giving when you are *supposed to* he confers a new level of responsibility on those who can donate to do so.

Graham, aged 67 and interviewed in 2006, was of the opinion that everyone needs to give but only; *if the blood is suitable or they have no violent antipathy to doing it.*

When asked to qualify what suitable meant, he said that the blood had to be safe, from someone who was trusted and agreed to follow the rules – here, he was in agreement with the previous donor's (Inger's) comment. By this I understood that the donor follows the known rules of modern-day giving, i.e. maintaining a suitable lifestyle for giving. This is a further example of risk difference across generations. The older donors were concerned to reduce the risk from their behaviour, the younger ones were

concerned with the risk being managed by the NHSBT. Moreover, here we have the conflation of social expectations on the donor as a good citizen and expectations on the NHSBT to use the blood for morally and medically suitable purposes.

A further aspect to the risk portfolio of blood is its relation to health and healthiness, not only as it would first appear to the recipient, but, as is illustrated by the accounts here, also in relation to the donor's health. Health and the requisite risk-free behaviours required for it to be both achieved and maintained are a central area for social science enquiry (Annandale, 2003; Nettleton, 2006). The links between identity and lifestyle have relevance for the identity of the risk-free blood donor. Therefore, rather than just giving blood out of altruistic endeavour, blood donation has become an elaborate exchange system; thus the accounts from donors about why they gave, it is argued here, did not solely exhibit an altruistic trend. The donors I encountered introduced a different aspect that related to the giving of blood as a risk management exchange system, and in doing so demonstrated public displays of good citizenship; for example, only turning up to give blood if they knew they were well enough and tolerating the physical procedures.

The risk profile as applied to blood is also related to being healthy enough to give rather than just being suitable to give. Definitions of health and healthiness are a modern focus; Nettleton (2006:33) asserts that we are living in an increasingly "healthiest" society. This is reflective of the main influences in the modern era, e.g. commoditisation and consumerism together with the emergence of a healthiest lifestyle. Nearly all the respondents considered their donation or donating behaviour related in some way to

their health, present, potential or in the past. I illustrate this with a selection of accounts from across the time frame of the study.

For example, two respondents who were donors and had accompanied each other to a session in 2004, were concerned that their lifestyle should make them too much of a risk to give blood, especially their diet. Vivienne, 41, said: *I feel that it is odd that I haven't been asked about my diet when I go to donate, ever, and thinking about it I feel guilty. I'm going to see if I can become a better donor – but don't think I'm healthy enough!*

She and her friend looked at each other and laughed, referring to the amount of wine they drink. This indicates that they considered donors to be better than the ordinary people or special; maybe their blood was safer. When asked what sort of person a donor was she laughed saying: *Someone who looks after their blood and their body, you know, they are careful about what they put into it.* By this she clarified that she meant no junk food and no risky behaviour, thus reaffirming the notion that blood may be at risk from the body in which it is housed rather than only from external forces such as viruses. Sara, was a professional (surveyor) female, aged 40 with two children. She had never been a donor once, and like her friend Vivienne believed that only people who were healthy enough should really be able to donate: *I think they should ask about diet; it would certainly make me watch what I eat and drink, especially leading up to my appointment.*

This idea was further communicated by another respondent, Peter, 35, interviewed in 2007, who informed me that he had just finished a portion of chips prior to going to donate. He said: *I shouldn't really be eating this stuff. Think of what it will be doing to my blood. They will find my blood fat up. They may not even want it and ban me!* Peter



was, in his words, *from a long line of donors* and was concerned that he would be: *sent away till I behave. I have been abroad and my diet has gone to rack and ruin. Oh well, at least I am trying to give, even if I have to wait till my blood is better.* This is a new idea that blood can get “ill” due to the behaviour of the host and become a risk.

## **5.10 Rituals to control the risk**

So far this chapter has argued that the ever-widening debate and list of deferment criteria is possibly a way in which the public and individual donors control the risks both to recipients and to who can take on the label of blood donor. The regular updating and monitoring of deferment criteria is a response to the loss of control in the safety of the blood supply (Healy, 2006), as was discussed in Chapter 3: Literature Review. The following is a quote from the most recent advice given on deferment of men who have had sex with other men:<sup>24</sup>

Blood donation works on the principles of kindness and mutual trust and we ask all potential and existing donors to adhere to the blood donor selection criteria by providing completely honest answers to all the questions asked, both for the protection of their own health and that of others. Donor selection criteria that are proportionate and based purely on evidence are necessary to help ensure that donors comply with the health check process. Compliance with all donor selection criteria is crucial in order to ensure the continued safety of the blood supply. Anyone may require a blood transfusion in the future and it is in the best interests of us all to ensure that we strive to maintain blood safety.

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<sup>24</sup> [www.blood.co.uk/can-i-give-blood/exclusion/](http://www.blood.co.uk/can-i-give-blood/exclusion/)

It asks potential donors to comply with the truth and honestly expected of donors rather than the preceding life-long ban applied to this group of potential donors, which was felt to be too risk controlling and potentially ruled out a lot of safe donors.

Douglas (2002:116–7) argued that the interpretation of rituals and treatment of the body, and in particular those parts which are taboo or polluted, for example, potentially infected blood, are controlled by ritual. These rituals, i.e. what is done to whom, by whom and why, are in fact “an image of society”. In the case of blood from the disabled, the elderly and people whose sexual practices are considered different or tainted, the exclusion from blood donor duty, once an exemplar of the good citizen, now reflects the marginalisation of these groups in society. Douglas’ socio-cultural theory of pollution enables a re-examination of the risk controls active in societies or groups, especially small, voluntary ones like the NHSBT, which correspond with the group/grid theory in a low group/low grid perspective (Wildavsky and Douglas, 1982:139). This, they argue, allows cultural analysis of public interest groups similar to the micro societies that the donor sessions may be characterised as, and enables us to understand how the donors whom I met were accepting of exclusion with the exception of the elderly donor (Caplan, 2000:9).

As rituals act to extend the images in society, this section of the chapter examines what rituals further control the management of risk. Rituals were evident in the process and framework for blood donation risk management. The table where I carried out my research was actually a place of ritual, where the blood donors had to spend time disengaging with the activity of blood giving. The tea and biscuits ritual was a vital one in several respects. Firstly, it was the “thank you” ritual for the gift; it would be

unacceptable social practice to offer nothing. Secondly, the period of time during which donors were expected to join in with this ritual was at face value a resting place after their labour; it was a place to be monitored in case of any physiological effects. Finally, it was a literal ceremonial passing of one status to another. One donor said he had to leave: *My recovery time is over, back to my normal life now*. The donor finishes their refreshment and is then able to return to normal life. During my period of observation, it was very rare for the donors to leave straight away. They all liked to recover with a simple biscuit and tea from a huge stainless steel urn, overseen by the tea lady. Although the donors did not communicate with each other, the tea ceremony was a way of making the donors visible and not anonymous. There were other rituals too, such as the pumping of the hand during the actual procedure, as if the donor was literally removing the blood by themselves. The donors in my study always performed the same post-donation rituals of looking at the plaster covering the cotton wool; they also all took time to roll down the sleeve of their clothing. They always took the helping hand of the person helping them off the trolley, looked at the equipment holding their blood, and then they headed to the tea table.

Another ritual related to risk control was the reading of any literature available about new policy. The leaflets were placed on the tables in the waiting areas, and any new posters were tacked to the lead panels. They were to remind attendees to “declare any change in status”. This, it is argued here, is creating a “border” whereby donors need to be affirmed as being safe to donate, similar to the processes of border control. This border control serves to carefully control the environs of blood donation and to separate it out from the ordinary world.

## 5.11 Conclusion

This chapter has related the fieldwork to risk theory, altruism and the new risk portfolios related to blood and the donor. It has provided evidence from the donors on the emergence of new risk symbolism, rather than solely altruism, attached to donated blood. It has also raised similarities and differences about what donors think about risk and blood, and has challenged the acceptance of altruism as the underpinning social force which supports contemporary blood donation in the UK. The motivation for donors, it is argued here, is that they donate to keep the blood supply free from risk and to ensure that the risks of not having sufficient blood quantity or blood types is minimised.

This chapter has applied risk theories and related the data from the fieldwork to these important concepts. It also provided evidence that donors understand that they must be certain that the blood they give is safe. They must do this by ensuring they are healthy enough to give rather than attend to donate and be told that they cannot give their blood. It has identified a new set of risks attached to the risk portfolio of blood. The chapter gives narratives of how the risks are controlled and managed by the donors themselves.

Once again I refer back to the WHO as the 2010 World Blood Day encapsulates this new concern and caveat about blood and blood donation.<sup>25</sup> The WHO continued with its campaign of risk reduction, calling for “new blood for the world”. It is urging the youth of the world to provide the “safest blood possible”.

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<sup>25</sup> [www.who.int/worldblooddonorday/en](http://www.who.int/worldblooddonorday/en)

This chapter reprised the ideas about blood and gift giving in relation to the gift of life paradigm. It related the narratives from respondents and examined the content to reveal new risk-related rather than altruistic-related discourse. The themes elucidated emerging commentary that blood is a risk until proven otherwise, and that excluding everyone considered risky is the new way forward as opposed to trusting risky “givers” to exclude themselves. The chapter has shown that blood donation has a central role as a metaphor of the overarching themes in modern Britain, those of risk management, individual responsibility and active citizenship rather than the historical good citizen of the past. It has also examined the emergent issue of citizenship in relation to donating blood and relayed the stories about what the action of giving means to donors in relation to controlling risks and contamination of the blood supply.

The next chapter is an extension of the concepts identified here, and it concentrates on the defining characteristic concerned with risk and blood donation, that of being unable to be or prevented from being a blood donor: being deferred or excluded.

## **Chapter 6 Deferment and Citizenship: Too Risky to Give**

### **6.1 Introduction: Risk, deferment and the donor citizen**

This chapter is aimed at exploring the data relating it to the changing nature of who can give blood and why some cannot. As such it is concerned with further exposing the limitations of the altruistic paradigm and by reviewing the Maussian (1990) theory of losing face in the case of deferment of donor status i.e. the gift being refused, what this means for the role of citizenship and blood donation.

Connotations of citizenship were identified referring to the work of Marshall (1950) in Chapter 3 Literature Review as a starting point for how the emerging blood donor service unwittingly espoused the altruistic fervour behind blood donation in post war Britain. Recent changes in blood donor lifestyle behaviour and justification for becoming and remaining a blood donor exposit changes in social constructions of citizenship in contemporary Britain, it is argued in this chapter. Public health surveillance has offered new self-surveillance responsibilities to donors, which they seem to understand, and Lupton (2000:99) argued that in the new citizenship in the context of the risk society (Beck, 1992), citizens are required to be vigilant in their own contribution to the ever-growing risk portfolios. Many of my respondents linked the role

of the blood donor to a demonstrable act of a good citizen. A good citizen for the blood donors is someone, it seems from the accounts I collected, who looks after themselves, their body, who they have sexual intercourse with, what they eat and even where they go on holiday, but also knows when not to come to donate. This chapter relates the data from my donor informants concerning their own deferment experiences and what they thought about who should be deferred and when deferment should take place. The deferment policy at the time of submission of this thesis was in dispute. The deferment criteria at the time included those over 65, disability sufferers, men who admitted to having had sex with men and those who admitted to taking intravenous drugs<sup>26</sup>. Throughout the length of time of the study, this aspect was a feature in two types of ways. The first way was one in which strategies employed by the NHSBT were accepted as the right way to manage the risk, and the second was in how being deferred affected the self.

This second aspect of deferment is related to the Maussian theories of “losing face” if the gift relationship falls foul of deferment policy. This chapter will start by defining deferment and describe the process of donating. It uses data from the donors to illustrate the concept that despite blood donation being regarded as a voluntary event, in fact some people are just “too risky to give”. The chapter also links the theories of moral panic to blood donation, and finally it examines the rituals which enable the process of giving blood to be safe and confined.

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<sup>26</sup> [https://secure.blood.co.uk/c11\\_cant.asp](https://secure.blood.co.uk/c11_cant.asp)

Deferment issues are centred on and around the notion discussed in the preceding chapter that both donors and donated blood are a source of risk in society. Busch (2003), in relation to risks associated with blood donation, highlights that as one type of danger recedes another one takes the space, and in the case of blood safety issues argues that as the risk of major infections statistically diminishes, the public concentrate on relatively minor issues, e.g. bruising, and it is argued here in this next chapter that the overarching concern of risk to the blood supply is not in the actual blood, but rather in the actual donor, and in the changing perceptions about risk in the popular culture (Ungar, 2001).

Within Titmuss' respondents' cosmology the greatest risk was the lack of truth-telling in the donor. Risk was considered also to be from donors rather than from the blood itself, i.e. his so called skid row donors (1997:167). I argue that today the greatest risk is the failure of the NHSBT and other agencies involved in the procurement of human blood to protect potential users from receiving damaged goods in the form of contaminated blood; e.g. the scandal of the infiltration and subsequent spread to recipients of the West Nile Virus (Busch et al., 2005)<sup>27</sup>. The purpose of physical and verbal screening which precedes each and every potential donor session is to exclude these sorts of risk, rather than in contrast the inclusion of as many people as possible,

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<sup>27</sup> <http://www.blood.co.uk/can-i-give-blood/west-nile-virus/>



creating a further challenge to the altruism paradigm and making a paradigm based on deferment rather than altruism.

Thus the cornerstone for any voluntary system of donation is that the donors are trustworthy (Arrow, 1972; Titmuss, 1997), and increasingly issues of trust are created and managed through models of citizenship. The concept of the “active citizen” in relation to donation was explored in Chapter 3 Literature Review and is evident in the informants’ testimonies. This notion can be theorised in relation to the previously identified themes of the shared body and the notion that all citizens are required to be active in their pursuit of both their own health and that of the community around them, with the overall aim to eliminate risk from their gift – blood (Petersen and Lupton, 1996). Rose and Novas (2002:5) have argued that a new kind of citizenship is emerging, that of biological citizenship. They argue that this is transforming the understood notion of citizenship, and that ideas about citizenship have shaped the ways in which individuals relate to themselves as well as their bodies. It creates what they call “a regime of the self”. This regime is prudent and self-responsible. Thus those people who fall under the deferment categories may well be construed by the general public as being the opposite of those very pro-citizen like attributes. Part of the contemporary citizenship template as applied to blood donors is indeed to be both prudent and self-responsible.

Moral panic theory (Cohen, 2002) has been referred to in the introduction and in the preceding chapter in relation to issues of misuse of blood or in the infection of the blood supply. The theory of moral panic in relation to this chapter is extended to the concept of deferment, which is central to the premise of this chapter. The moral panic cascade

was, it seemed, in relation to this fieldwork, applied at intervals to the beliefs and practices concerned with blood donation and the blood supply in relation to how the donors experienced the potential for deferment via the ever-widening screening out of would-be donors. Therefore, the idea of different types of lifestyle and individuals becoming labelled via moral panic “too risky” was a theme that emerged towards the end of the fieldwork. For example, this chapter presents data related to the elderly, the disabled and those described as being not able to give blood because it was too risky for the person.

## **6.2 Deferment and citizenship**

The moral underpinnings of blood donation are, it is argued, in the flux of change in relation to the evidence from my data. The moral basis for altruism is very different from the morals engaged with when operating a donor system based on rights to citizenship and morals based on lifestyle. In Chapter 3 Literature Review I looked at how using Mauss (1990) could enable understanding of the notion of the free gift. I now use his work in another way to further my argument that the blood giving relationship has changed. Mauss (1990) endeavoured in his essay on the gift to describe the phenomena of exchange with regards to both the morality and the organisation required in such social transactions. At the heart, then, of social gift exchange systems according to Mauss (1990:5) are that the transactions are inherently linked to the prevailing morality. In his conclusion (1990:83), he asserts that the unreciprocated gift is problematic and in modern societies morality and legalisation should correspond. The issue of “gay” blood, as discussed with reference to the pressure group “Blood

Ban” in Chapter 5, “From Gift to Risk: Challenging the Orthodoxy of Altruism” usefully articulates the concept of tainted blood and how the outrage at being considered a risk and thus being excluded from a civic duty can affect blood donation. This can be related to Maussian theory in the following way. Mauss (1990:11) in his seminal book *The Gift* sets out the obligations and reciprocal requirements that need to be heeded in order for stable gift exchange mechanisms to occur. These entwined obligations, to offer, to give, to receive, to accept and to repay, are crucial to the premise of the gift exchange cycle, which is the blood donation system in the UK. Failing in any one aspect, Mauss opined, produces severe social strains that affect all parties. Refusing to accept is just as problematic as refusing to give. “Face is lost forever,” wrote Mauss (1990:41). The idea that one is deferred from donor status against one’s will is an example of this.

Valentine (2005:114) has added to the debate concerning blood donation, citizenship and identity; he comments that voluntary blood donations have been codified and made open to sanction. In his concept of a new model of donation, the moral imperative is to give correctly, and deferring imposes a new “self” on the donor, that of not being good enough to donate, and therefore challenges the concepts of both mutual trust and altruism in relation to voluntary donation. Becoming a donor created a new or other identity for many of my respondents, for example one donor said: *I feel like I am part of the community, feel it is a socially responsible thing to do, shows I care*. In relation to those with a family history of donating blood, becoming a donor confers a family-related identity on them, as well as furthering their family or kinship identity (Lawler, 2008:34). It also impacts on the innate need to belong and take part in a safe as risk-

free society. In the preceding Chapter 5, it was argued that blood has become as much a symbol of risk as it used to be a symbol of trust, mutuality and community cohesion.

### **6.3 Too risky to give**

The deferment of “donor” status occurs, it is argued here, when the risk is too big for society to take. This has ramifications for what it means to be free to give a gift without restraint and raises further aspects of citizenship as applied to the role of a blood donor. The majority of my participants recorded being a donor felt like the “right thing to do” or a “civic duty”. Some said it was the right thing to do, and although everyone should donate as it acted to link them to society, it was perceived in reality that not everyone could. Risk management via regular screening and excluding was an accepted part of the modern-day donation process.

The data from my fieldwork raised issues to do with people who could be at risk and those who were considered too risky to give. Many of the donors said that blood donating was “not something everyone could do”. This turned out to be a regularly occurring phrase. This is at the heart of the way in which contemporary modes of good citizenship clash with the presumed altruistic free-to-enter role of blood donor.

The donors listed a variety of reasons for deferment, for example illness, lifestyle and age. This was related to the risk reduction process that the donors had had to go through to become “donors”. The process of screening, which each person has to undergo to become a donor, is worthy of description here as it aids understanding of why some of the respondents understood that giving blood is not an act that is solely in the gift of the donor anymore. The process is a public declaration of your suitability and emblematic

of moral suitability to give, and in relation to my arguments in the preceding Chapter 5 deferment denies the donor the capacity to be a good and active citizen. The exclusion criteria for UK donors are divided into two categories<sup>28</sup>; there are conditions or situations whereby the person “should not” or “may not”. The “should not” criteria related to the immediate health of the donors, for example if they have or have recently had a virus or course of antibiotics. It also excludes acupuncture, tattoos and cosmetic treatments, unless by an approved therapist. The “may not” criteria include some types of recent surgery and complicated dental work. People may not donate blood within 24 hours of a simple filling or having had immunisations. These are useful to highlight in the context of this chapter, because they illustrate how easy it is to become deferred.

This is what one donor told me happens to them after they have arrived. The person first undergoes a general health check using the health check form they are asked to complete on arrival, including discussion of issues concerned with travel and sexual health, and a finger is pricked to get a drop of blood to check the haemoglobin level in the blood and the blood typing or group. Donors also agree to be tested for Human Immunodeficiency Virus (HIV), various strains of hepatitis and syphilis, and the donor has to weigh at least 50kg. This process occurs every time the person presents themselves as a donor. The donor is asked if they understand the risks attached to donating, and if they can declare that they are not carrying a viral infection such as HIV (see link below for example)<sup>29</sup>. The donor cannot just turn up to give blood, even if they

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<sup>28</sup> [https://secure.blood.co.uk/c11\\_cant.asp](https://secure.blood.co.uk/c11_cant.asp)

<sup>29</sup> [www.scotblood.co.uk/media/272/donor-information-leaflet2.pdf](http://www.scotblood.co.uk/media/272/donor-information-leaflet2.pdf)

have a long history of donating. It requires great self control to “keep on giving” as many of the respondents phrased it. This self control is voiced in some of the respondents. Many of the respondents did say that not everyone can give, especially after they had been donating for a while and had experienced the changes in the screening process. They said that the NHSBT ask them more than they had in the past. One donor put it: *They were happy that we just turned up in the old days!* Another person, Jed, said he kept himself fit enough to give by training every night: *I train five nights a week to keep healthy; you need to be fit and healthy to give blood.* Andrew, another donor in his mid-twenties, related his fitness behaviour to his role of blood donor, also saying that he was fit enough to donate as he trained by running and going to the local gym a few times a week. Both Andrew and Jed were displaying the physical as well as the moral commitment desired in modern blood donors. Illustrative of this new moral code whereby reasons for deferment are being intrinsically bound to morality, is the changing focus of the World Health Organisation’s World Blood Day, which was discussed previously in Chapter 5, and has altered the focus of the day to illustrate the issues to do with giving safe blood.

The concept of corporeal responsibility is easily extrapolated to blood responsibility and good citizenship and demonstrated by the clear understanding of the link to keeping a good body, to the notion of keeping your blood clean. Being a blood donator is being a good citizen, being a regular one due to a good regime is even better. Donors were keen to say exactly how many times they had donated – the range being from the first time to 45 times to underline this enduring capacity of good citizenship.

For example, using blood donating was one way in which nearly all of the respondents displayed their “active citizenship”. This is illustrated by the testimonies below. Janette, 53, a female hospital worker, said: *I am just pleased to have done something worthwhile. It is easy and has huge benefits for others.* Further evidence comes from other donors, such as Abigail, who in 2004 said: *I feel that I make some contribution to the community; I hope that I can help someone else to enough life. Education of the public will bring out more donors and the understanding that good health and fitness allow you to remain active to donate.*

A further avenue for debate is, as Strong (2009) argues, that the blood supply has become an index or metaphor for national security and public good. He suggests that the ways in which risks are managed by exclusion of risky groups reveal issues in society about individualism, citizenship and the greater public good. He refers to the banning of gay blood donors. Strong’s paper has strong resonance for the findings of my study. For example, the problem of male gay donors known as category MSM (men who have had sex with men in blood donation jargon) was an issue for many of the respondents, who wrote down rather than voiced their concerns about HIV and gay blood donors: *It [the blood supply] needs to be safe for everyone, there is no other way of doing it, and I suppose they can take from each other and give it back to each other,* referring to allowing male homosexuals to only give and receive from each other. This was a sensitive topic, although not a regularly recurring theme at the table, due to the fact that those in the MSM category were automatically excluded via deferment. These types of comments allude to exclusion being seen as an accepted part of blood donor behaviour.

## 6.4 Age, disability and deferment

It seemed from the talk at the recovery table that it was now accepted to manage the blood supply around those who are, said simply by one donor, “too risky to give”, for example age, disability and sexuality.

As a consequence of conducting the fieldwork within a donating area and not in the reception, I did not often meet those who were deferred. But over the time of the study, necessarily some who had been deferred returned to “active donation”. Some of the donors, however, did make reference to those who had been deferred, and especially to how they felt about being deferred due to being variously too thin or too old, for example, as referred to in the preceding Chapter 5. However, a variety of reactions were reported in relation to this stigma being conferred upon previously safe people. For example, below is a selection of comments from the fieldwork about what it means to be “not good enough” and therefore in relation to Mauss (1990) there is a loss of face. This leads to tensions between those people who want to donate, and are refused the choice of doing so.

Alan attended a blood donor session with his wife, and although not actually donating himself that day he wanted to make a contribution. He was annoyed that although he could still drive he could not give blood as he was now too old. Another perspective would be that, as Alan said: *My blood is too old*. He had given previously; even after having had jaundice his blood had been accepted until age became a reason for deferment, and this distressed him and his idea that it was his right to give if he wanted



to: *Now over the age limit – previously blood was accepted from jaundice sufferers, so I gave blood until too old. Now it's me who drives her here as she is too ill to drive!*

Clearly, he did not like being “over the age limit”, which is a form of deferment. Alan was visibly upset at having to sit by and watch others give blood, especially his wife. He wanted to know what this age limit was for and said to me that I should check with the “Blood Service” to ascertain if the reason was that the elderly are more likely to need blood themselves. He said it sounded like he was a drunk driver and made him feel like he had done something wrong. This was especially upsetting as he was a healthy person: *It is ridiculous; I am able to pursue any activity that I require or want to – even driving her here!*

As defined both here in this chapter and in Chapter 3 Literature Review, deferment means that some people who want to give are barred from doing so. However, it is argued here in this chapter, it increasingly means that the moral and legal climate concur with the decision to exclude another group of would-be donors, those people labelled disabled. This process is tolerated for the safety of everyone, including those who are deferred. There has been recent politicisation of blood as a result of these risk management processes. Students in universities are “banning the bus”. This is in response to homosexual students not being allowed to donate<sup>30</sup>.

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<sup>30</sup> <http://www.nus.org.uk/en/news/news/nus-welcomes-end-to-lifetime-gay-blood-ban-after-years-of-campaigning/>

Further issues with deferment centre on whether disabilism is affecting the right to give, since disability sufferers are not free to give. Disabilism refers to an attitude or behaviours towards disability sufferers of many types, who are discriminated against on the basis that their condition inhibits their ability to perform or join in with able-bodied people.

Recent reviews of how the NHSBT interface and use disabled potential donors were the subject of their 2006 Disability Equality Scheme (NHSBT, 2006). This is a serious issue, as throughout all the fieldwork not one disabled donor was seen or interviewed, moreover none of those interviewed referred to themselves as having a “disability”. None of my respondents were disabled, and when a group at the recovery table were asked: “Should disabled people donate blood?” their response was that they should only be excluded on the same grounds as others. Other responses centred on whether they would be at risk of becoming ill or were in greater need than non-disabled people. The perceived identity of the disabled did not include being a donor. This was illustrated by Angie, who said: *I think they should be able to, as long as it doesn't make them ill, if you know what I mean. Aren't they more likely to need a transfusion rather than give it? That sounds terrible!*

## 6.5 Management of deferment issues

The interest in what Valentine (2005:6) called the politicisation of deferment has led to deferment to be the subject of a special concern with the issues related to donation<sup>31</sup>. As noted by many of the respondents, there seems to be an added new reason to defer regularly. For Valentine blood donation is seen as the quintessential act of altruism from which an ever-increasing number is excluded. The 2009 Blood Transfusion annual review document's main aim is to reduce risk to the recipients of donations whom it termed customers. It also states that the current safe supply of blood is dependent on both the altruism and loyalty of donors.

The newly-formed NHS Blood and Transplant (NHSBT) body made 2009 the year of donation to reset the cultural clock about what risks are present in blood and to respond to complaints about deferment. It allowed 70-year-olds to give blood if they have given in the preceding two years (10% of donors are over sixty).

Natalie had returned to active donation after what she termed as “a long break”. She had given blood regularly for a year since the break, but she did not elaborate on the reasons she had had for stopping. However, the answer to the written question concerning what had made her donate was: *I saw the transfusion bus and realised that I was heavy enough to donate again*. This was, I inferred, a comment on the fact that she had not stopped giving as such, but rather had been “deferred” due to her body mass index

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<sup>31</sup> [www.blood.co.uk/can-i-give-blood/exclusion](http://www.blood.co.uk/can-i-give-blood/exclusion)

being too low to donate. Thus she had previously been made to feel excluded as a result of her body weight not being high enough for her to give blood.

Angie, 18, was deferred for a similar reason: *I was stopped from giving blood due to my anorexia. It made me think about myself, so it was a good thing because I now know I have to eat properly to allow me to contribute to society.*

A further, more vivid example of how deferment, or being turned away, puts a strain on the donor system relationship comes from a session on a Tuesday before Christmas, to which I have referred in the preceding Chapter 5. I had arranged to attend this session as I wanted to see if there was a different atmosphere in what would be a traditional altruistic period. From where I was sitting I could hear snippets of conversation as the donors were telling their story, hoping not to be deferred. It was about 7pm and I was forced to look up. There was a commotion in the normally quiet hall (except for Radio 1). The noise was unusual, as previously the ambience of the sessions had been quasi-medical, quiet and controlled, with the donors being passive grateful cogs in the wheel. I witnessed a man in his mid-thirties arriving in a flustered state. It was wet and he was shaking off the rain. He had given his name and was waiting to sit down. An experienced donor, I thought, as he seemed to be aware of the procedure. He was therefore surprised that he was “not on the list”, and he was asked whether he could come back at the time given to him (donors are invited by letter). He then responded to the receptionist in the following way: *I have made a big effort to get here tonight – especially at this time of the year. I thought you would not turn anyone away as it’s near Christmas. Anyway, you had better check as my blood is one of the special types, the rare ones they are always going on about not having enough of.*

The response was: *So many people have turned up that we can't see any more, as the waiting time is too long as it is.* With this he became agitated and left shouting: *No wonder hardly anyone gives blood – you make it so difficult. Take me off the list.* It is clear from this that the donor had “lost face”.

This illustrates that donors like to give their special gift, and they really do take it personally if they are deferred or refused for any reason. It is as if blood donating is a right that has to be exercised. The waiting room itself took a while to recover from this interchange. I observed that the waiting donors still did not discuss the incident amongst themselves. In this respect just accepting a donation would have been the wrong way of managing modern blood donating, as there would be chaos if everyone turned up late.

The concept of blood donation is built around the understanding that blood is so desperately needed that anyone and everyone should give, thus not being allowed to express this right leads to tension. In early interview sessions for this research some participants expressed anger when their perceived right to give was denied, in the evening sessions particularly. Towards the later stages of the fieldwork the waiting area in the donation room was merged with the reception waiting room and there was one donor who was asked not to wait to donate as he was not “suitable today”. The news was audible to the recovery table and there was an exchange of glances; however, no one commented on this public refusal of the gift. Although no one said anything, the body language of the “successful donors” was easy to read; they had made it through the screening but not everyone who turns up can. It felt to me like a lottery. This also reinforces to donors the specialness of those who are allowed to give. Bestowing the

right to give has become a new gift, the gift of the NHSBT rather than the donor gifting their blood.

The Archer Report (2008) was a direct response to the moral panic concerned with the infection of haemophiliacs by contaminated blood. Although not a government review, such was the moral panic this independent inquiry had created that the solutions required rules to exclude unsuitable blood and would-be donors. Moral panics about blood refine the understanding of what it is to be able to be and remain a blood donor.

Deferment issues are mediated by their exposure in the media. Throughout the study there were examples of moral panics related to the blood supply; however, the donors were silent. One of the social mechanisms, which it can be argued controls blood donation in the UK, is the media coverage of both “good” and “bad” blood. As a result, discussions concerning blood and risk need to be related to moral panic theory. Moral panic emerges to assuage social anxieties. In recent years blood supplies and mistakes have indeed created the social conditions requisite for moral panics to occur. Ungar (2001) has argued that moral panics focus on the social control of dispossessed groups. Many episodes in recent years have thrown blood donation into a moral panic trajectory (Cohen, 2002; Garland, 2005). This had resulted in the creation of potentially deviant blood donors and of deviant groups, whose relationship to the blood donor system needs regulation and possible exclusion.

In relation to my findings I found that panics about blood are phenomena which come and go. For example, I examined the data to investigate this idea and observed an undulating expression of risk and concern. Some donors were silent and some were reflective of how well the blood supply was protected from risky behaviours on all

sides. The purpose of the moral panic cascade is to create a solution to the problem and to advertise the resultant protection mechanism put in place, for example, a change in policy.

Earlier interviews reveal greater risk awareness and expression of moral panic. As I commenced data collection and fieldwork, later respondents did not express any ideas about blood being a risk to others. This was, of course, linked to the context of donating, and in the data gathered there is a difference in perception in relation to background events. The clear message from the recovery table was that “the Service”, as the NHSBT was known, existed not only to collect the blood, but it also ensured that “only those who should” donated. Once again the language of the donors gives a clear message in using the word “should” in relation to donation; they are telling the story of the change from past times when “everyone who can” was expected to donate.

## **6.6 Ableness**

Language used by my donors about being deferred, banned or being allowed to give centred on a term many of them used, that of being “able to donate”. This allowed the development of a key aspect of this chapter in that the onus of ableness falls to the NHSBT to confer on a person rather than the people who want to donate conferring on themselves and that characteristic of the modern-day donor now includes the capacity of “ableness”. This concept of “ableness” includes an array of both bodily and moral constraints, as well as those more recent ones concerning lifestyle and the condition of your blood.

Amberley, aged 23, said in 2004 that people should only donate if they are able to, with no religious grounds to prevent them doing so. She felt it was a moral issue as she was religious herself, therefore not everyone can give due to religious constraints. Becoming a blood donor, therefore, for her required some notion of moral rights and wrongs.

Another issue related to bodily capacity was the fear of needles when giving blood, which impeded the ability to give. The fear of needles was cited by several donors as the reason why not everyone can become a donor; some people just are not able to manage the physical side of donation. Being too ill to give was better than being too risky to give, it seemed. One aspect of this ableness was the idea that, as said by several donors, at least they should come for a check-up, and then they would *know that they are not able to*. One donor said that he had in fact only started to donate, because he had thought in the 1980s when the HIV panic arrived, that it was *a way to get checked out to see if I was positive – a way of bypassing the official channels*. Given the very low percentage of the population who donate in relation to the potential, it was surprising that there seemed to be a tolerance of this inability to give.

Natalie, whom I met in 2005, felt that people should not be pressured or made to feel obliged to become donors: *not everyone can*, and June, aged 38 in 2009, agreed saying: *Becoming a donor is an entirely private and personal choice*. Therefore these views taken across the duration of the study concur. Those donors who felt that donation was a private choice seemed more likely to overestimate the background population rate. For example, Freda aged 39, said in 2009 that the percentage of the population which donated was 39%. Sue, aged 62, did not know how many people donated. It seems from my data that donors who knew how few people actually did donate seemed to apply



more pressure to become “able to donate” than those who overestimated the donating population.

Therefore, if the capacity to give blood is determined by other factors than just medically identified deferral, should donors get rewarded for this specialness? Queenie, aged 56, said that just being able to give her blood was enough for her. The worldview of donors is that if they do the donating then the blood will be safer than if others who are “not able to” did it. This theme came up very regularly. Jed was a typical example, saying: *Not everyone should have to donate blood, but perhaps those engaged in working for the civil service, police, military, etc.*

This is interesting, as he seemed to feel that those identified groups have a greater obligation to give their blood by virtue of their occupation being in some way a service occupation; by default of their occupation their blood is automatically safer. Jed was not alone in presenting this specialness. Another donor, Darren, who was a male donor of 28 and did not reveal the length of time for which he had been a donor, did not feel that everyone could or should donate blood and said that around 10% of the UK population were regular blood donors. Others, like John, said that only if your blood was suitable could it be given. Robin, who was a police officer, concurred with Jed in that he felt more pressured to give blood than the general population saying it goes with the job. This is also a potential expression of the good citizen being seen through roles such as the blood donor; the “donor citizen” (Powell et al., 2006). Valentine (2005:123) asserts that the donor is identified by the non-donating public as “a compassionate and more generous citizen than normal”. The donors in my study didn’t overtly present themselves as compassionate, rather they were seeing themselves as someone who

could and therefore should, adding to this concept of “ableness”. In his study, the recipients of blood valued the blood transfusion more if the blood came from a voluntary rather than paid-for donor, because they knew the voluntary donor’s donation held more meaning for the donor. In Britain all blood donors remain voluntary. Lupton (2007) argued that the risk actor in society reacts to a variety of social forces in order to create “boundary control” (Douglas, 2002). The behaviour of my donors could be interpreted as a form of boundary control mechanism, for example, in order to keep the “gift” safe. These new mechanisms relate to understanding who can offer to give their blood, rather than solely offering to give. The rules have changed illustrating the relationship between risk, citizenship and blood donation.

These accounts and evidence from the respondents relate to the notion that what was once classified as a “gift” has in fact joined the ever-growing plethora of real or imagined risks in modern society. Contemporary citizens have become highly aware and anxious about risk, as Beck’s (1992) influential analysis revealed. Beck (1992:55) argued that the population was caught up in a defensive battle, needing to anticipate and avoid hostile substances around them. He encapsulated the dilemma that has become more entrenched about risk: that it is not clear whether it is the risks that have intensified or our view of them. Ordinary people are in a constant state of concern about how they relate to both known and unknown risks; this applies to both the blood source and supply as cogently as to any other environmental or health-related risk.

Tulloch and Lupton (2003) studied definitions of risk; their study found that risk was categorised as a negative feeling wherein the self and others were insecure and out of control in relation to their daily life and activities, and that risk management was a part

of modern daily life. Caplan (2000) has also revisited the modern-day perceptions and societal understanding of risk, and argues that the impact of the risks in everyday life has augmented the concept of individualism, which is a characteristic of contemporary societies and this in turn affects the role of the citizen in health related circumstances. These theories have some relation to the donors in my study. In 2006, 181 donations were found to be infected out of 1.4 million registered donors. In that year the reviewing body, the Health Protection Agency (HPA), reported that donated blood is collected from unpaid adult donors who do not acknowledge any medical condition, travel history or behaviours that would put them at an increased risk, and that all donations were tested for a battery of viral infections. If any is found, such as HIV, hepatitis B or C, T-lymphocyte, tropical viruses, syphilis, etc., then the blood is removed from the system and the donor is referred for treatment. Donors and the public are overestimating the risk or reacting in a socially protective way to control the risk potential in the collecting and redistribution of blood.

## **6.7 Conclusion**

This chapter has deconstructed the concept of deferment in relation to new social forces that control who can be deferred or prevented from acquiring the status of blood donor. Deferment was related to the breakdown of the altruistic paradigm of blood donation as the concept of altruism does not include ideation of refusal of gifts. To be deferred has connotations of both losing face and increasingly in being a bad citizen.

This chapter also related data to the rise of the “donor citizen”. It has provided evidence that good citizenship, not altruism, is at the heart of the contemporary blood donor

world. It has raised this issue in relation to the relative “ableness” of safe donors and the riskiness of those considered too different to give. It has also presented an argument that being refused the perceived right to give acts to harm future donating behaviour as well as impacting on the perceived right to give and thereby attain the identity of a good citizen. It has also raised the issue of citizenship in relation to donating blood, and relayed the stories about what the action of giving means to donors in relation to controlling risks and contamination of the blood supply. The concept of “ableness” was derived at via narratives of the donors and it is within this ableness that good citizenship and management of deferment is constructed. Ableness is a particularly positive construct which relates to bodily as well as moral ableness.

Particular themes elucidated emerging commentary that the person, not the blood, is a risk until proven otherwise, and that excluding everyone considered risky is the new way forward as opposed to trusting risky “givers” to demonstrate good and active citizenship and exclude themselves. Thus the chapter highlighted that other social forces such as disabilism and ageism are active in the processes which lead to being unable to take part in the public action of good citizenship exemplified by the blood donor.

The next chapter builds on these ideas, where I link the idea of community risk to the notion of not simply giving blood, but giving it to get safe blood back. The chapter extends the reassessment of the gift relationship of blood donation to the prevailing perceptions of risk in donors at a typical blood donor session.

## **Chapter 7 Giving to Get Back: From Altruism to Covenant**

### **7.1 Introduction**

So far, I have presented evidence of change in relation to blood donation and have argued that the activity has become more than emblematic of general unfettered altruism. The thesis has related theories of risk and citizenship in relation to issues created by deferment from blood donation to explain these changes in the preceding chapters. In order for these changes, which I have argued have occurred, to be fully understood, it is now necessary to turn to another aspect of altruism and the relationship not of the gift to society, but that between the donors and who they give blood for. The introduction highlighted that the central aim of the thesis was to revisit the central tenet of blood donors being first and foremost altruistic in nature. The limitations of the altruistic paradigm have been raised earlier and this chapter uses data which suggests that Titmuss could have looked further to explain the behaviours of blood donors in explaining the rationale behind their gift.

The preceding chapters (5 and 6) analysed evidence from the fieldwork that related to the societal perceptions of the nature of blood, from being a safe and trustworthy gift to

becoming a “risk-related” substance that requires careful social control and management. Those chapters argued that blood donation is moving beyond the idea that blood donation is created via altruistic donation and the newly embedded ideas of reciprocal citizenship and risk management. The received definitions of altruism incorporate acting in a way which is centred on unselfish concern for the welfare of others. This definition is not always the case as this selection of data illustrates. These themes became evident early in the pilot study, though not explored in the literature to my knowledge at that time (2005). They have subsequently been examined in similar research, although not in the same ways (Busby, 2006; Sharp, 2007; Shaw, 2009).

The data also suggested that the majority of donors give their safe blood to get a similar product back. This chapter argues that the social force that creates donation is derived out of a new rationale for giving, i.e. that of what I have termed the “giving to get back” philosophy or motivation and that this change derives out of individual rather than community interest.

Thus, this chapter further develops the challenge of altruism as the sole motive for giving blood, arguing that it has become only one of many social forces that trigger donors to come forward and in it I concentrate on who donors give their deposit of blood for, rather than why they give blood, which was the thrust of Chapter 5. This chapter further develops the risk management mechanisms analysed in Chapter 5, employed by donors to ensure that the risky groups and individuals do not get back what they did not deposit. The data which emerged as a result of my talking to donors in the donating sessions suggested that, in fact, the bad risk individuals should not actually benefit from the probity and careful behaviour of those who give their blood, and that

blood donation is not a voluntary donation given away for free. This chapter will also analyse a further related aspect of the breakdown of altruistic spirit and community trust; that of mutuality.

This chapter reassesses key areas associated with the gift relationship being understood as an altruistic mediated public action and historically related to blood donation (Titmuss, 1997; Tutton, 2002) by applying theories of what I argue has become covenanted altruistic behaviour, detailed in the literature review, to notions of mutuality, community and new concepts of kinship and family credit donation. The purpose of this chapter, therefore, is to explore the theory that donors “covenant” rather than donate their blood.

### **7.1 From altruism to covenanted donations: Who do we give for?**

During the fieldwork, donors were asked why they gave blood at the outset; a question that had already been answered by Titmuss (1997). However, the early data contained a variety of responses that led me to consider that a change had occurred in the motivation, and that the donation was a contingent rather than a free one for giving. The responses from the donors about blood donation revealed that there was a gathering theme, for example, that introduced the notion that donating was a “civic duty” or “the right thing to do these days”. Wendy (2007) had been a donor for 26 years, and she said: *I have seen many changes since then, mostly to do with attitude of staff and how they take it – blood. They used to be more grateful; now it is as though you should be doing it. I have given a lot over time so there should be no trouble should I need it back.*

This quote encapsulates the crux of this changed motivations and justifications. It evidences further changes in the relationship the donor has with the collecting agent, the NHSBT and wider society.

Motives for these changes in contemporary donation behaviour appear to be more complicated than altruism or philanthropy, and as such require further analysis to glean the true rationale or reasons behind contemporary donating behaviour. The most salient aspect of what my donors said was the adjunct “these days” which was voiced by many of the informants, and it is, as argued here, indicative of a change in the relations between giving behaviour and society.

Busby (2004) also observed this change of what I have termed “giving to get back” rather than solely giving; she highlighted that:

Amongst the contemporary NBS donors interviewed, the term “gift” was only occasionally used in relation to donated blood more often though; they talked about a blood bank. Blood was seen as being donated to a “bank” which donors themselves or their relatives, friends or strangers can draw on if needed. This was seen as one way of making mutual provision for the risks of the kind of traumatic accident or illness that may afflict people without warning.

I want to draw out this distinction between giving for strangers or for designated others below, as within my study the majority of respondents were concerned to highlight that the reason for their blood donation was family related, as opposed to their blood being given to any strangers. Moreover, my research informants did not refer to strangers. Rather, it was the opposite; they were very clear about who may not get their donation. This is synonymous with the research on social networks carried out by Leider et al.



(2009) whose study which was conducted online revealed that the expected “baseline” altruism seemed to have been replaced by directed altruistic behaviour. This agrees with the findings presented here of the emergence of an extended or different pro-social behaviour, the “giving to get back” philosophy, rather than the “just giving” one of the past.

This appeared to confirm my earlier findings, which argue that blood had shifted from being a pure gift to being more of a covenanted gift or a deposit. Busby (2004) also highlighted mutuality via family action in relation to blood donating. The donated blood is given for oneself or family by more recently recruited donors, it seems, rather than for altruistic motives which characterised older or more longstanding donors, with the donation from new or younger donors being related to future need.

Here in the UK, blood donation has been understood through the lens of the voluntary donor paradigm; therefore, unlike other countries, issues to do with buying and selling blood have not affected the role of the donor (Arrow, 1974). However, when voluntary and unpaid donors give their blood is the process voluntary and is the donation really free and unconditional?

Despite the largely universal reversion to “voluntary” donation (WHO, 2010), Copeman (2005) reflects on what this term actually means for understanding present-day relationships between donation and altruism. The first issue for Copeman when reassessing altruism and blood is that donation reminds us of the power of our body. Blood has a developing, at present, “economy” of its own; for example, the new value ascribed to umbilical cord blood has transformed what used to be waste into being a valuable clinical component of blood (Waldby and Mitchell, 2007:111). This is a major

change in the area of blood donation, where paid-for blood is seen to be more of a gift than blood collected via voluntary donation. More components and constituents of donated blood are being regarded as both economically and clinically viable; umbilical cord blood is an example.

Blood is becoming a potential economic asset, especially if it is “rare”, and it has become a form of new body capital and bio-identity according to studies by Waldby, Rosengarten et al. (2004). At present, these economies are potential rather than actual due to the regulations governing the giving of anatomical gifts in the UK (Human Tissue Act, 2008). However, as the concept of economic value emerges in relation to blood donation in contemporary society, blood donation can, it is argued, be understood as a simple act of goodness or duty by the small percentage of the population who give it, and this is evidenced within my data presented here. Respondents in this study understood the social value of their donated blood, but none voiced the notion that the blood could be seen to have economic value.

Coleman (2004) argued that the process of blood donation is not able to conform to the full theoretical application of altruism according to Mauss (1990), as the way in which contemporary societies including Britain organise and distribute the gift does not cater for the visual confirmation that the gift has been received. This has relevance for the data in this chapter.

However, there was an assumption by one donor that the NHSBT service was trusted to see that the gift was received by a suitable receiver. In relation to altruistic or covenant donating of blood, Sonia, who was a long-time donor, said: *I am a blood donor because relatives have benefited from donations. I am glad I can do something in return and am*

*not concerned with what else is done to blood after its collection – I have done my bit. I think it is used for transfusions and research. I trust the Service [NHSBT] give it to the right people.*

Other donors, Agnes for example, said she was happy about what the National Health Service did with her donation as she said: *I have read all the leaflets and feel that they do a good job – you know only doling it out to the right people.*

Nicky, aged 59, who has donated around 15-20 times said: *I only have the vaguest idea, my job is to donate and I trust the NBS [his words] to use my blood wisely.*

These quotes are illustrative of straight altruism mediated through the trust by donors in the NHSBT.

## **7.2 Specialness and the Feel Good factor**

This section presents narrative from the donors, whereby they regard blood donors as “special” rather than altruistic. By this I mean that rather like some occupations being singled out as suitable donor occupations, it seems that some types of people, as well as some types of blood, make the donation special. As a result they feel the need to donate rather than being free to donate as would an altruistic donor.

Lewis was a man in his fifties who had donated blood for five years. He became a blood donor after he had had a motorbike accident and lost a lot of blood. He really felt that giving blood was actually helping someone. He also felt that he should give back what he “took”, saying that he had needed 100 pints to save his life. He knew he was

exaggerating, he said, but it felt like he had: *used up all the blood* and he: *felt indebted to those who were “special enough” to save my life.*

Robin, as a further example echoing this theme, interviewed in 2004, said he had been a donor for four years. He had become a donor because: *My mother donates, and it is a family thing, and I thought it would be giving something back to the NHS. I also know the value of blood as I see a lot of blood spilt as a police officer.* Robin seemed genuinely perplexed by the question as to why he donated; it was a simple reason for him, although he did not realise the significance of his statements that were indicative of how complex the gift relationship with blood is. He said he was simply giving, but also that he was giving back to the NHS, as he was always in casualty being in the police force. The police force, it seemed, was being regarded as a special occupation and as having a responsibility to stand up and donate.

These comments are relevant because the donor is not repaying the community, but the NHS. Robin sees his donation as going straight to the NHS and not as a donation for another person. He alluded elsewhere in the interview to the “specialness” of some occupations that work for the community, and therefore their being at greater risk of needing blood than ordinary people. This notion of “specialness” of occupations was a reoccurring feature, with the expectation that blood will be available for the Service (NHSBT) and protecting occupations. This is why Robin sees his blood donation going to the point of distribution, the NHSBT.

Marion, who had been a donor for approximately ten years, felt that her rational for becoming a blood donor was nothing to do with being a good person: *My son gets*

*anaemic every so often and has received twelve pints so far - so I am really only here so I am replacing it so there is some in the system for him.*

Other donors, like Agnes, had never had a blood transfusion – she was lucky she said and as such not giving out of altruism, but rather from a need to give safe blood so she got it back should she need it.

This notion of the specialness of certain blood and blood givers ensures a high standard to allow safe or special blood-types or components to be returned or gifted back to the givers – in effect, therefore, within these covenants only safe givers can give and agree to be screened: *We [donors] are screened to see if you – not your blood – are good enough*, said Agnes.

These reasons for giving could be what Healy (2000:56) has argued as organisational rather than individual altruism. In a study about altruism and blood donors he argued that donors were in effect sort of elusive altruists, and that despite superficial vestiges of altruism by and large, donation does not occur because of what he terms “thriving pockets of altruism”. The following evidence from my data illustrates that this is true. As a result, therefore, the underlying motives for giving are not based on community spirit.

This change in motives for giving may be why there is public concern, as expressed in the Archer Report (2008) referred to in the preceding two chapters. In relation to the motives for the NHS at the time buying blood from what the report termed “skid row” donors, the report concluded that at the time commercial, not safety, interests took precedence over public health safety. If blood is not available to vulnerable groups in

their time of need, for example soldiers and victims of terrorist attacks or haemophiliacs, problems occur. Some respondents highlighted that they were only giving to *those groups who need it*; this is those who need to fight infections and who are too sick to donate themselves. Therefore, some donors are obligated to donate, rather than having altruistic reasons, because the special nature of their blood type carries special responsibility, which once revealed makes it impossible not to donate. For example, donors of blood types perceived to be special said that once they knew their blood was a special type, they had to come forward.

Alan was an older donor who had been: *donating for a long-time now – since I found out that I was negative I felt the need and obligation.*

Bonnie also linked the extra need to blood type saying that as she was: *O Negative - it is more worthwhile for special blood types to become donors.*

A further challenge to the position of altruism was that the fieldwork environment itself did not transmit a feeling of altruism. Rather, there was an atmosphere of purposeful need. The individualism displayed by the donors, highlighted in the methodology section, and the physical process of giving did not really lend themselves to people demonstrating their altruism or otherwise. This is why it was important for some donors to write down their reasons for giving or verbalise them to me. They came because they had to for reasons related to their family or wider society safety (Ferguson and Chandler, 2005; Lemmings et al., 2005).

Pinker (2006) argued that being free to give blood is not as simple a relationship with society as it appears. Altruism is only possible, he argues, when needs are met in society

through collectivist values prevailing in the social market. The actual type of altruism that currently prevails, therefore, is a form of conditional altruism. I am postulating here that blood had altered its cultural symbolism from one of open gift given free to now being a gift with conditions. The needs are met in society by careful regulation of the blood services as is highlighted severally by my informants. They, in effect, give blood to the NHSBT rather than members of society.

A further aspect to the giving relationship, which emerged in the language of the donors, was that of benevolence or munificence rather than altruism. It was in fact related to themselves as individuals, as opposed to being good for society in general. Donors said that giving blood was a *good thing to do* as well as the *right thing to do*. For example, Andrew said that blood donating made him feel good about himself in relation to his community, and Jeremy said it made him feel like he had done something to help those in need, it make him feel not that he had done something good, but that he felt better about himself.

Connie said that she gives today in case she needs some *in the future*. This idea of benevolence rather than altruism has been highlighted recently in the literature. Ferguson, Farrell and Lawrence (2008) argue that blood donation campaigns should focus on personal rather than societal benefits of donation as a measure to enhance blood donation levels.

Another account that introduced a further novel aspect to the giving for the self-gratification trajectory was that of Estelle. Estelle reported that the reasons for her giving blood were centred on two issues: *Because I know it is needed and it also makes me feel good. It gives me the feel-good factor*. She laughed, as she was a bit

embarrassed at revealing the truth. She went on to add that she personally would give away: *anything, as long as I'm dead or can do without it!* She was not sure about receiving another person's body part. Importantly, in relation to my argument here, she said: *I haven't even had a blood transfusion and no one in my immediate family has needed one either – I don't know why I do it apart from it makes me feel good about myself, like I said, the feel-good factor.*

This is interesting, since Estelle was not giving to get back but because she wants to feel like a good person. She was an experienced donor of blood, having given 15 or so units; this is a period of four years or more, so it is a regular event in her life. She said that everyone should give blood, but only with the proviso that *they are okay with needles and haven't got infectious diseases.* This is in keeping with the philosophy of safe people giving safe blood highlighted in other areas of the thesis.

This “feel-good factor” was a phrase which was to reoccur throughout the accounts. Donors were asked why they gave blood and many said the same thing. This is not the same feeling as altruistic donation; it is related to the individualism of the donor and not in the interests of the wider unknown community. Titmuss (1997:297) relayed the centrality of the “do-good” factor which has potentially been replaced by the “feel-good” factor.

### **7.3 Media, the vicarious receipt of the gift and the first timers**

One area where challenging the orthodoxy of altruism may be of used is in the explaining of the existence of once-only donors. They may not experience the reciprocity invited and required in the altruistic way. The decision to become a blood



donor is triggered by several factors such as family and personal need for blood, but a further factor which is of increasing importance is the Media. This may be further the alteration in style of the recent NHSBT media campaigns that personalise and individualise the link between the giver and the gift recipient. This is more likely to invoke a relationship with both the wider society and the NHSBT, which is changing its campaign to be in line with Copeman's (2005) research. Recent campaigns have been concerned with transmitting the message that "once is not enough", which was the message embedded in the World Blood Day of 2008<sup>32</sup>. Giving blood once does not turn you into a blood donor and all the benefits that status confers on the person in terms of perceptions of either altruism or good citizenship.

The role of the media acting as a bridge between the individual and society is one aspect where we can see the changes I propose have taken place. By this, I mean that the media is now transmitting information about whom you should give blood for, in an effort to keep existing donors and trap new donors. Media campaigns and adverts evidence a vicarious rather than direct recognition of the gift. In recent literature (December 2008) leaflets ask "What will it take for you to give blood?" and blood giving is related to the needs of direct family members, specifically mentioning sons, mothers and fathers. This is a change to earlier leaflets, which were based on inherent altruistic behaviour, saying: "Save a life." In 2010, videos relate giving blood back to the person's own or family need, citing need for blood for use within situations that the majority of the population can relate to e.g. road traffic accidents, chemotherapy, etc. There is no mention of

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<sup>32</sup> [www.who.int/worldblooddonorday/archives/2008/en/index.html](http://www.who.int/worldblooddonorday/archives/2008/en/index.html)

Titmuss' universal stranger, i.e. the anonymous person in need whose need reaches out to the moral virtuousness of the giver (Oakley, 1996).

The change of emphasis in recruiting donors was directed at the societal changes that have made community spirit a nostalgic event, and the new adverts from 2002 consciously used a different emphasis by using the family as a reason for donation rather than "just saving lives". Moreover, they used celebrities' need for blood to further personalise the donation rather than retain this communal concept of donor deposit. Donors are putting the deposit in the bank still, as they were in the past, but contemporary people do it for someone they actually know, even if that is vicariously via a TV show.<sup>33</sup>

In a further example of how ideas of altruism are not the whole story about the reasons for donor behaviour, Nilsson-Sojka and Sojka (2007) in a study about motives for donation reported that, although altruism was the most common motive for donating blood and continuing to be an active one, a significant other factor for first-time donors was the direct influence from friends and relatives, with a 47% weighting given to the question "influence from a friend".

This study was significant in numbers but did not reveal the impact of direct family influence on both starting and continuing to be blood donors as is revealed in my study. Ben, a student aged 21 interviewed in 2007, said: *I only give blood in the hope that it*

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<sup>33</sup> [www.bloodco.uk](http://www.bloodco.uk) video-audio-leaflets/ accessed 18/1/10 11:40

*goes to a normal person – not a down and out. There is no way I am going to give blood if it is going to be given to some junkie or homosexual.*

The sentiments voiced above are not atypical of those expressed by the people I came into contact with. They tell us about the new gift relationships present in society. Interpretation of the differences in understanding the currency of the exchange is required in order to make sense of the motivation or rationale of giving. When analysing the data it was noted that there was some difference in the language used by donors to describe the same action; some said *giving* blood, others said *donating* blood. From this, I argue, the value for some donors who ‘give’ rather than ‘donate’ their blood may hint at the differing motivations behind blood donation. Therefore, when reflecting on why they give rather than donate blood, the answers largely were spread over three key categories discussed here: family, friends and the individualistic feel-good factor.

Royse (1999) explored ways to retain first-time volunteer blood donors and concluded that the interval between donations was too long to foster a change in identity. Moreover, the actual giving of blood may be too physically onerous for many.

I give some examples of this from my fieldwork. The youngest donor, who was 17, was actually pale and shaky in the donating bed. His brother was already sitting with me watching, saying to me that it would be his turn soon, and laughing at his brother saying things to egg him on: *Hope it is a good pint.* The donor, Peter, was shaky and had to be helped to the table. The tea lady was told to watch him as he was a first timer. The few first timers I met were enthusiastic and buoyant at their bravery, one account saying he was here despite not liking needles. The others were a little lost at the anonymity after the giving. One said: *After all the build up – is that it? Maybe the Blood Service needs*

*to look at making the first-time experience of giving a little more special to ensure that they come back.* These new donors were entering into what they thought was a reciprocal relationship, and as I met them they seemed disappointed at the lack of celebration they received at being a new, first-time donor. This was illustrated by Peter who said as he rolled down his sleeve *is that it?* This is indicative of how the blood donation process at sessions such as I attended does not comply with the concept of altruism, as the giver does not get to see the value of their gift.

#### **7.4 Donation as drama and mutuality**

A further aspect of the debate that I want to relate to the changed nature of publicly demonstrable altruism surrounds the ambience of giving, to see if this supports the theory of “giving to get back”. The observations of blood donation by Titmuss led him to suggest that the process was steeped in community interest and solidarity. Did my experiences in the field convey to me that blood is given in the same ambience? Thus this part of the chapter presents an additional perspective to the feelings of mutuality and altruism transmitted via the ethos of solidarity and mutual aid, as described by Titmuss in his 1965 paper “Social Welfare and the Art of Giving” as “the good and the bad risks sharing one another’s lot” (Alcock, Glennister et al., 2001:131). By re-examining the physical location and the act of giving, and reflecting on the social drama of giving and the physical presentation of the donor, we can relate it to the demise of mutuality and the rise of individualism in society. Titmuss (1997:131) argued that these new sites of community similar to the sessions of blood donation were “microcosms of community”, and the role of ambience in creating solidarity and community was

highlighted in contemporary UK. I would argue that the act of donation is still dramaturgical; however, the symbolism attached to it needs to be reinterpreted to become commensurate with the reasons for giving today. Donors act out a dramaturgical message, but now anonymity and risk reduction replace the message of safety and solidarity. I will turn now to the drama of giving to see if any aspect of the donation process serves to display the new donating behaviour.

I have provided a description of the geography of the locale in Chapter 4, the chapter situating the research aimed at conveying the ambience. At the outset the actual context of giving looks the same, but I am arguing that this needs reanalysis. Titmuss, (1965 cited in Alcock et al., 2001:165) in trying to make some interpretations of society and policy as the post-war transfusion service became countrywide, argued:

By means of a great network of friendly societies, medical clubs, chapel Societies, brotherhoods, cooperatives, trade unions and savings clubs, schemes of mutual insurance were developed as a method of prepayment for Services. Members could claim when they were in need – in sickness; disablement, unemployment, old age, widowhood, and death. The ‘good’ risks and the ‘bad’ risks, the young and the old, shared one another’s lot.

Simmel (1908, ch.3 and 5), as referred to in the literature review, argues that society exists where a number of individuals enter into interaction. This interaction is purposeful in achieving desired aims for the mutual benefit of that society. They create subsequent unity or socialisation, and this unity is derived from the sum of interactions. Oakley (1996) echoed this and argued that the donation of blood is at the heart of social relations as they are experienced, a view also put forward by Arrow (1974). This means that the blood donation can be used as a metaphor of social change and interaction. The

change in contemporary Britain is that the good and bad risks are not a shared concern. In this way blood donation may be regarded as being representative or microcosmic of the wider society feeling about who is the recipient of gifts and donations.

It is also important to note here that according to the respondents, the blood needs to be shown to be safe at both ends of the exchange process, in the state it is given as well as the state it is received. This is a further change in the exchange relations in blood donation in contemporary UK. Therefore, the sum of value takes into account this “safeness” factor. Donors within my study did not express any understanding of the complicated potential politicisation of blood, although some – only eight out of the 77 interviews – did display some knowledge of what their blood was really used for. These donors understood that their gift was going to be broken down and used in separate component bits rather than in the state it was given. Others like Nicky, who was a 59-year-old female donor, said that she only had the “vague idea” what happens to her blood, despite being a regular donor of 15 or so times. Therefore, it could be argued that the majority of donors were largely insular about the process and use of blood, with the major underlying factor seeming to be that there is enough for when they need it. Copeman (2005:41) argues that donors in India give blood to secure generatively for those saved by their blood. Moreover, slogans for blood donors link goodness through donation of blood to blessings in the later life. This is to relate to their culture of the afterlife and the amount of blessings a person has collected through community related acts.

The ambience of the donating sessions; rather, the process of giving blood was rushed and chaotic and largely removed from the person donating it rather than being a special

experience. The staff focused on the arm of the person and the blood coming out of it and the donors were, as they later said, “left to get on with it”, once the cannula and other equipment were secured. The staff were more concerned to deal with the blood correctly, ensuring that donors kept clenching and unclenching their fist to get a good flow, otherwise *the blood might not be good enough*, as relayed by Sue, one of the staff. Another donor helper said: *We are rushed off our feet every session, with so many samples and different bottles to fill and label, especially if it is rare. If I make a mistake and put something in the wrong place, it could all get lost or labelled incorrectly. Once it is out, you’ve just got to process it as fast as you can, and get on with the next one.*

It was a bit like watching a cow being milked, with all the tubing and attaching to arms and bottles. The process was functional and aseptic; it did not seem steeped in history and goodness. The person was secondary to the procedure; even the donor focused on their arm and what was coming out of it towards the end of their donation time. This is in contrast to the studies by Street (2009:197) who described the experiences of face-to-face transfusion, that the recipient and the giver both focused their attentions on the blood flowing from one arm to another. She says that blood transfusion is unlike other hidden medical practices, and that it stands out as a moment of pure exposure and visibility, whereby the blood flows mechanically from one receptacle to another.

Blood donation has been used as an embodiment of social exchange and solidarity, in some way exemplifying the acting out of the drama of safety and solidarity and individual trust. The donors in the past knew each other coming to the place of community; either church hall or community hall was probably selected for the

ceremonial site of giving as a method of underwriting the social nature of giving blood in post-war Britain.

My initial experience of the “table” is as described below. Having never been a blood donor, I expected something more akin to Titmuss’ post-war homage as depicted in the famous Tony Hancock sketch *The Blood Donor*<sup>34</sup>. Instead, I found that from my study something different. I noticed that the donors never interacted with each other; there was no feeling of camaraderie at the table and the body language of the donors was not expansive. They averted their eyes and concentrated on the refreshments in virtual silence. I needed to ascertain as to whether the table was always silent, or was it because of me? I had expected the field to be more open and animated and, I suppose, communal. The informants, the nurse and the tea lady mentioned this aspect, telling me: *The donors, they keep themselves to themselves; they come in, donate, have a cup of tea and go on their way. That’s it.* However, the donors were individually reflective and concerned for their part in the blood donation drama, but only until they were included in the drama.

In contemporary UK, I would argue that, although the act of donation is still dramaturgical, the symbolism attached to it needs to be reinterpreted to become commensurate with the reasons for giving today. Donors act out a dramaturgical message, and now anonymity and risk reduction replace the message of safety and solidarity. For example, Paul, a 52-year-old banker in the city interviewed in the study

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<sup>34</sup> <http://www.youtube.com/watch?v=ZH6dfp8rqpo>



in 2008, said: *Blood – yes, it is very interesting [he had studied sociology a long time ago] I don't give – they [NBSBT] used to come to the office in the old days. It made it difficult not to give when the whole office was watching. Should give, really – you never know when you need it at our age! [laughs] When you think about it, at least you knew who was turning up to give and could trust them.*

Paul is saying two things here to illustrate the old drama of trust and hint at the new drama of risk of not having enough blood in supply. The drama is intended to show the power of the blood-collecting authority to prove the truth-telling of the donor rather than take the individual on trust.

## **7.5 Giving for the future, family and social insurance – blood giving as emotional labour**

In the Chapter 1, Introduction, I argued the ethnography would employ a Foucaudian perspective. Foucault (1977) comments that for a society that is dominated by death, blood constitutes one of its fundamental values; blood is instrumental in preserving order and, through its shedding, creating disorder. He compares “sanguinity” to society in that people are through it a society connected by blood. He argues that power can speak through blood. “Blood was a reality with symbolic function.” (Rabinow, 1984:269) Foucault theorises social action and individual agency, arguing that social regulation and interaction is concerned with power. He traces the changes in individual perception and interpretation through the rise of scientific knowledge at the expense of the previous source of power, religion with “God” at its epicentre. The regulation, economy, and latterly sickness management in societies was through the control of

specialised knowledge, biomedicine and other closed professions. Any individuals not “acting” appropriately were excluded from normal society by the use and sanction of these power bases. The embodied self was a willing partner wanting to be regulated and controlled, both sexually and mentally, as well as bodily. Society saw alterations in behaviour that sought to keep the body private, continent and under the scrutiny of the professions (Foucault, 1977; Armstrong, 1983; B Turner, 2001).

The vast majority of donors related the activity of blood donating in some way back to their family and as a result this presents the theory that contemporary donors, as well as “giving to get back” for themselves, give blood to get it back for their family rather than giving for anonymous recipients. The relationship of family members to the role of donor was something nearly all respondents voiced as being significant in the motivation to become or remain a blood donor; this has been identified in other studies as far back as Howden-Chapman et al. (1996).

This part of the chapter explores the related themes concerned with family, kinship and mutuality and relates them to the theory of directed or covenanted altruistic donation rather than altruism alone. It will be examining the role of family tradition and relating it to concepts of directed altruism, especially those families who are in need or in danger due to safety issues in the blood supply service, in relation to the data gathered. Directed altruism allows direction of the gift not to random or universal recipients as in Titmuss’ paradigm, rather, directed altruism favours direction of the gift to family. Leider et al. (2009) argue that the altruism of gift exchange was linked to family and friends and less likely to be directed at or for random strangers. As this is the premise behind the voluntary blood service in the UK, it would be expected to find that donors would be

accepting of their gift being directed to random strangers; however the data below challenges this assumption.

A much stronger theme that emerged was that of whom the donors were giving for. The vast majority were there to donate because giving blood had family links. This section will start by examining the role of the family or family ties as the vector or rationale for being involved in blood giving, and it introduces ideas such as tradition, the concept of “donor families” and the burden or stress that goes with it.

The link to family was demonstrated by the language my respondents used. Liz said: *I do it because my parents did and I have really positive memories of it, like the biscuits and juice. They used to give me that even when I hadn't given; it was a treat!* She was recollecting the way in which the Service was represented to her, in that it was a community event at local level and it was a family event as well. As she looked around, it was even the same hall and that brought back memories for her. She was also describing a difference in time. Time in the past was linked to interaction and reciprocity. The atmosphere I encountered was very different; time was measured in giving up free time or paid labour time to come to the donation session. Donors pointed out that now the blood services did not go to work-based venues; the donors had to make time to be blood donors. They cited times such as their lunch hour and straight after work. This made them special and able at the same time.

Aged 54, Sonia had donated 15 times. She said: *No, not everyone can give. Some choose not to for ethical or religious reasons.* She believed that blood donating was “down to the individual”. She went further to explain: *I haven't had a transfusion myself, but my daughter has had one and my husband also has had several operations.*

For Sonia, this meant that by giving she was giving back as well as knowing the importance of blood, and, as she said, other body part trade in modern societies: *The whole thing runs on things like blood*, she said referring to the NHSBT.

However there were examples of altruistic giving that were not family related, and could be explained by generational differences, e.g. Sue who was 62. She had donated her blood 25 times. She thought about the ideas about everyone being a blood donor and said: *No, I could not approve of such a level of coercion – I don't know how many people give*. This comment seems to be contradictory, with the donor having been in the donating environment for such a long time. Sue had never had a blood transfusion – so her longevity as a donor was not, in fact related to any form of pay back or deposit.

Another older donor, June, who was interviewed in 2008, revealed a pertinent area from this perspective. She was alluding to mutuality, rather than altruism, as the continued drive to donate: *I like to feel I am making a difference and that someone would do the same for me if I needed it! I don't want to say how many times I have done this [donated]. It is not something I talk about*. June felt that the work of the donor was *both a private and a personal choice*.

It is attempted in this analysis to interpret contemporary altruistic behaviour as a form of covenant linking the donor with the wider society. By this, I mean that any baseline altruistic behaviour is now at the background in giving blood, and this has become underwritten by the depositing of blood as a way of pledging – or promising – a future relationship with blood after its donation. This is in contrast to the relationship donors had with their blood, in that the relationship ended once the donation was completed.

The definition of covenant is more formal, but I am extrapolating the concept to allow exploration of the change concerning the body's relationship with its blood.

## **7.6 From family credit to donor credit and a covenant system**

The following sections of the chapter extend our understanding of the new covenanted family-centred giving. Titmuss (1990:134) talked about the “family credit donor”, describing how the paid-for blood schemes in the United States meant that by depositing a pint of blood the blood went towards how much any one in your family could take back when the need arose. This type of system is very different from the one in the UK, and in the initial questions put to donors the word “family” was not used overtly to allow for any contemporary link to emerge naturally out of the data. Although Titmuss did include this type of donor in his typology of US donors, he did not publish any qualitative data for us to read. This study provides verbal and written evidence that the family donor is working on a deposit or credit system rather than altruism when they donate. Titmuss says that by giving a pre-deposit donation of one pint of blood they become “insured” for their blood needs for at least a year. Further, these donors are acting as a “good provider” and “family-centred” (1990:135). Despite the differences across time and health systems, the evidence from my study has resonance for these ideas.

The “giving behaviour” of many of the respondents was in some way linked not only to the family experience but also to seeing the Blood Service as a sort of bank where you deposit your blood, in the understanding that you get it back when and if you need it. This understanding is also indicated in a vicarious way in that the deposit is a safeguard

for others in your family. It will also be a way of ensuring that the work of biomedicine and research can go on in case “one” is in need of it, according to some informants. Titmuss referred to the family donors as being seen as blood lenders – certain groups of safe, regular blood on loan for the majority. One donor, Sonia, said in relation to altruistic or covenant donating of blood: *I give blood because relatives have benefited from donations – glad I can do something in return.* Sonia was not concerned with what else was done to blood after its collection: *I think it is used for transfusions and research.* She felt that the NHSBT would do things properly.

This reveals a new perspective of the altruism related to blood donation. Starr (1998:54) argued that as blood has become a pharmaceutical product it has come to symbolise a new social system.

One of the people I interviewed early on in the project expressed his family link. Andrew revealed a family tie when responding to the invitation to answer a questionnaire. He first became a donor when he came to the Blood Service session with his uncle. He said it made him feel: *good about myself – my uncle gives blood, so I came with him. Blood giving [donating] runs in the family.* He was with his uncle and they both felt it was a way of keeping blood in the family and family tradition at the same time. Andrew and his uncle were local people who came to give on a regular basis. They demonstrated a local concept of giving – being visible in the church hall to demonstrate their community tradition. Even though they knew that the blood given back was not really their blood: *It just feels that way! Because it's here [referring to the church hall].* The idea that mobile blood sessions were under threat caused Andrew to

say: *We wouldn't feel the same or have the time to go anywhere else.* Thus, illustrating nostalgia and family-orientated processes related to these blood donors.

A further excerpt illustrates the power or central position of family in making people turn to donating blood as a way of keeping their family traditions and the acting out of being a good provider. Jordan was another long-serving donor, in this case one of 36 years. The catalyst to donating for this male respondent was, he said: *My parents donated and I feel I can give something back to help others.* He added the feeling: *I hope I can help someone else to enough life like they did.* When asked about why his parents decided to donate, he said it would have been linked to their position in society: *We were just that sort of family.* This respondent did not believe, though, that every person had a responsibility to be a donor. He also felt that donor cards should not be compulsory. He said that he would be happy to donate any form of organ or body part: *if it meant that I could give better health to someone else.* He also said that he was happy to receive all forms of donation. Once again, in response to questions about obligation and the potential compulsory nature of donor cards, this respondent felt that the choice to be a donor was important and that it should not be made compulsory.

Penny was another donor who embodied a family tradition of, as she put it, *being in the Service.* She completed the questionnaire and was interviewed in 2004. She was another female in her early sixties who reported: *My donating career has lasted 45 years. I decided to donate because my parents had donated and blood is needed; they were in the first batch of donors when it was set up [referring to the post-war NBS].*

She felt *glad to help* by the action of donating – again an altruistic theme emerging as present in the literature. She felt that the issue of donor cards could be dealt with, by

issuing all people when they are born with a card like an NHS card and it would be up to them *to activate it*. Others at the table thought this was a good idea. Penny further felt that donations should only be made willingly, and an individual should decide the fate of their body prior to death in relation to all aspects of bodily giving. Penny was clear that decisions concerning donation were to be individual, and like others with a long history of *being in the Service* she felt that when it came down to it, donating was an individual thing, but it was hard to go against family traditions.

Brian was a man in his fifties whom I met in 2004 at the start of the fieldwork, who had donated blood for five years. He became a blood donor after he had needed many pints to save his life. He had had a motorbike accident and lost a leg. He really felt that giving blood was actually helping someone. He also felt that he should give back what, as he said, *took*. He felt that having had a large transfusion, he should give back blood in case his family was in similar need.

A further example of this type of being a family credit style of donor was Henry, who had been a donor for four years at the time of completion of the questionnaire and the interview. He explained why he had become a donor: *My mother donates, and I thought it would be giving something back to the NHS following on the example she set, really – not something I thought about, just did it because it was the right thing to do for my family.*

Similarly, Matt (2004) was a male respondent aged 46 who had been donating for 26 years. He recalled that he was concerned with keeping healthy for the future and saw giving as part of that. He was not a solid organ donor – he did not know why – and said: *This sort of thing [interview] is good for making people think about things like that –*



*these days only giving blood may not be enough; maybe they should make blood donation the sort of opt out only if you need to, then more would do it.*

Sheila, another blood donor, was keen on the public understanding the importance of the *few* who keep the blood banks as full as they are. She also said she felt altruistic forces led some people to use an *experience* of needing blood as a way into giving something back *when the time comes*. For her, it was when she lost blood during an assault and needed lots of blood: *from people like me [i.e. donors], otherwise I wouldn't be here.*

Another donor, Freda, echoed this emotional aspect described by Sheila. Freda said that her feelings related to the giving of blood remained emotional, as: *I have a family member who has had four blood transfusions and was very emotional at the time – so it promoted thinking within the family about blood giving.* Once again, this donor was really only displaying a family-related altruism based on a family need or responsibility, linking blood giving to emotional labour. Although she was not comfortable with the process, she did it anyway as she had a family who would draw on the bank.

A more family loan related testimony was that of Clive, a 28-year-old male donor whose reasons for donating blood were *to make a difference and help others*. As well as this opinion, he echoed the family tradition sentiments. He had a strong family link with parents and siblings, who also donated: *a sort of syndicate*. Clive likened blood donation to being a syndicate. This idea is interesting, as a syndicate may be described as a group of people who combine to carry out a common purpose: creating a family of all blood donors coming together to contribute to the blood pool and get the dividend rewards of transfusion should they need it.

This was beginning to be extended into solid organ donation as well, he felt, an idea echoed by Healy (2006). Clive said: *I would only donate to close friends or family if in need of something particular like a kidney from me.* He went on to expand this distinction further, arguing that to give or receive from other than a close friend or relative *would be morally wrong.* He reviewed this again and reaffirmed this decision by saying: *No, I would only be happy receiving from family; all stuff, blood and blood products.* He did not go on to elaborate on whether family really meant same biological blood, which would have been interesting. For Clive then blood donation was about looking out for family rather than giving it for others.

A further family dimension was revealed by another interviewee. Lin was a 44-year-old female donor who took part in the study in 2007. She was similar in her reasons for donation in that she was doing it for her family rather than for the good of others. In response to a conversation about what part she would or would not give, she said: *I would all of the usual; heart, lungs, etc. only for my immediate family – don't know why – I think I could donate things like heart and bone marrow but only for my family.*

This highlights that there is a difference between biological and non-biological family. Lin said: *I think I could do [donate] the usual list, heart and lungs, you know, the big things, only for my family but no other things [face, tissues, etc].* Lin added that she was a donor because of her grandfather: *I am very interested in the Second World War. I used to have lots of chats with my granddad about issues and then decided to give blood asap.* Moreover, she was carrying the mantle of blood giving by saying: *I also bring my 12-year-old son along sometimes, and he is happy to start this [blood donating] when he is 17.*

Mandy, aged 26, said that blood had become invisible: *I mean, no one talks about it in that special way they used to – as though it was linked to God – so I agree that it has become less of a body part, if you know what I mean.* Mandy had said that she was Catholic, and that in her youth blood meant more as there was a regular link to church. Now blood was not something that carried sacredness as before.

### **7.7 “Giving” or “donating”? Is there a difference?**

This section examines the language used by the donors relating to their action. From this a new perspective of giving arises, one which reveals the act to be “giving to get back” as opposed to altruism. It is within these extremes of altruism and giving to get back that there may be a difference between donating and giving. Therefore we can link the choice of word used by donors to elicit understandings as to why they become and remain a blood donor in the contemporary Britain. Some donors said they were giving, some said they were donating. I wanted to explore whether there was any message in this choice of language in relation to the premise of this chapter, which is donations are only given for getting back. The donors who said they were *donating* were donating without incumbencies, but the ones who said they were *giving* were doing so with conditions attached. Donating their blood was linked to more expression of altruism; when a donor said *I am giving my blood* it was usually followed by some contingent information. This was in turn linked to risk reduction, paying back for a family member’s use or misfortune, and to ensure that the blood supply was sufficient should they need any treatment.

Some donors who had never needed what they termed the Blood Service were drawn to give blood to ensure that they had an “account” so to speak, such as Peter one of the youngest donors, who said *I have never needed to have blood thank God so I donate in case or when I need it*. There is evidence that other credit ideas are in the minds of donors, with many describing the giving as depositing. This is evidence of covenanted altruism. The donors used metaphors of the banking system, saying that the Blood Service was actually a blood “bank”, and as a corollary they were banking their blood. The blood was given as a covenant for preselected individuals, usually themselves, immediate family and occasionally sick people.

The use of the word donating as opposed to giving of blood is significant in the interpretation of blood donation in this thesis. Those people who say they “donate” mean just that – donate is to abandon all connection with the blood – as opposed to those who say they *give* blood. Donating infers a bestowing action, with the freedom for the recipient to do what they want with the gift. Giving may be more like “letting someone have”. This implies that the giver wants to have a say in the gift after it has been given. There is a subtle difference in meaning, which needs further analysis in relation to blood donation.

## **7.8 Conclusion**

The argument presented here in this chapter builds on that of the previous chapters, which revealed tensions in the role of altruism as the central social force that mediated blood donation in the UK. The chapter presented the idea of a covenant rather than

deposit being the underpinning rationale for donation, especially in relation to family and to future need for clean and safe blood.

This chapter has reinvestigated the concept of family and mutuality in the modern giving society. It has provided evidence to agree, over a quarter of a century later, that altruism is not a major social force in even family-centred giving. The chapter has also examined the role of the media in transmitting this change.

It has provided novel insight into the feelings of donors in relation to whether they are donating or giving. This may be construed as blood carrying different social relations regarding the concept of blood becoming inalienable from the giver if it is given or donated.

Social action, observed through the body, is therefore derived from practice and belief of the culture surrounding you. In a sense, one acts out one's culture through the medium of the body. The body in blood donation is acting a new role, one in which the body symbolises individuality and concern for only family rather than acting out concern for strangers. In a sense, one could argue that we have become, in Puttman's (2000) words, a society that "gives alone".

The next chapter, "Blood Donation, the Body and the Self", examines the relationship of this new donating body to its host "the self". It discusses the position of blood in relation to the individual, rather than on a population level as in this chapter, and extends the concept that blood has joined the list of bodily components for transfer and transplant and covenanted inalienable exchange.

## **Chapter 8 Blood Donation, the Body and the Self**

### **8.1 Introduction**

So far, this thesis has presented evidence which supports and expounds the argument made in the introductory chapter, that changes have taken place in the giving relationship in late modernity. These changes highlight the impact and sequelae of risk society and the dominance of biomedicine in relation to the management of blood donors and blood donation as referred to in the literature review. Further, the data was related to the role of citizenship in relation to ensuring a clean and safe blood supply in the contemporary world. The preceding chapters also served to illustrate changes in blood donation and donors' relationship to the wider society as well as revisiting issues related to blood donation such as family and social solidarity. These chapters have attempted to alert us to the cultural relocation of donated blood from the "gift of life paradigm" to one that is imbued with risk management and demonstrations of good citizenship. It has also been argued that a covenant or deposit-related relationship as opposed to one based upon traditional altruism is the major change as to why blood is donated and whom donors give blood for. Further, blood and its link to donation have

revealed that there are groups within society whose gift is not wanted and has resulted in tensions between those who can and those who are refused.

This chapter extends the scope of changes in blood donation, to enable further understanding of the changes identified in blood donation. It aims at addressing one of the themes of the thesis as identified in the Introduction, i.e. to indicate, on the basis of evidence from the fieldwork, the impact of developments in biomedicine, consumerism with regard to the self, blood donation and blood products. Blood donation has entered the body swap and donation world. Weiner (1992:36) argues all personal possessions invoke a connection with their owner, which symbolises the personal experience and adds to their overall identity. Blood donation is an example of this, as blood is increasingly seen as a body part; its donation or giving can tell us about the person and what the action of giving holds for them, and about the relationship of blood to the late postmodern body.

The chapter presents a variety of scenarios and narrative data from the fieldwork, illustrating changes in relation to objectives set out in the introduction and discussed within the literature review, that of the self and blood as a body part. In Chapter 3, referring to the work of Weiner (1992), blood was described as becoming inalienable, i.e. the donated blood remains in some way related to the donor in spirit after the blood has left the body. This chapter focuses on the blood donors' discourse about what happens to their blood after donation, to progress this notion. It is this change and the understanding of the new life blood has after donation that is entering the donor consciousness, which this chapter argues has made blood inalienable, creating further tensions within the altruistic paradigm.

Moreover, increasing use and reuse of a wider range of body parts and organs has created a growing percentage of the general population joining the “donor” fraternity as a result of receiving donor body parts through the impact of rapid technological advances. This has led to a change in the way the donated blood is perceived as a quasi body part in the consumer world. The impact of changing connotations of good citizenship has been highlighted previously. Being duty bound to engage in donating pieces of the body, either in life or after death, has created areas of change in the giving relationship as to how this commoditisation influences the understanding of the self and communal identity and donated blood. It also provides evidence from the donors configuring what I have called the hierarchy of the self to deal with the pre-understood modern-day commitment or norm that the body in late modernity is for sharing: donating something of you is increasingly seen as another example of good citizenship.

## **8.2 Hierarchy, the body and blood**

This section provides narrative of what was said about blood by the donors. The physical process of donation seems to be designed to create distance between the giver and the gift in that the arm is outstretched away from the body and usually the head is turned away so as not to feel or see the action of the cannula being inserted into the vein at the elbow. The majority of donors described this aspect of the procedure, which has been described in the preceding chapter as being a form of emotional labour or body work. Thus the physical action of giving, it is argued, has a further purpose, i.e. to separate out the self from the donated product. For example Shelley in 2009, aged 28, said:



*I don't like to look at it as it comes out – it would make me feel odd seeing that. I don't even like needles, no I don't think anyone looks; look [she was nodding to the donating trolleys] they are all looking away like me.*

The language used to talk about blood in the giving of it proved to be helpful to interpretation in this chapter of the thesis. Those involved in blood giving, when talking about their blood, used language that illustrates separation out or away from the self.

The donors said that they did not like to look at the whole procedure. They said, for example, that they turned away to look at the wall or look over the heads of the other people in the room and that they hated the whole thing. Some said that they preferred not to look at it as their blood made them queasy.

The donors never talked about blood in the first person (as their own) and neither did the staff; the blood was always referred to as “it”. This excerpt captures the concept of body work in relation to blood donation. The body itself is presented as the vehicle for donation rather than the person of the donor. The body donates rather than the donor and the physical expression or “body idiom” (Goffman, 1963) represents the distance between the donated blood and the self. The donated blood is “blood” not “my blood”. The donors said that it was something they could see rather than feel leaving their body. For example Angie (2006): *You don't feel it leaving you, it's just not that personal for me, there's no obvious change in me.*

Copeman (2009) provides us with a stark contrast in the physical process of giving in India. In his studies he depicts the blood donating process as a religious service with the blood, rather than the donor, becoming blessed whilst the donor has an audience at the

bedside. The language used by the Indian donors included “our blood”, which is in contrast to those in the UK and is representative of the notion that the giving of the blood, rather than the blood itself, is the communal act.

In contrast, here in the UK donation is reduced to clinical, not religious, ambience and as a result the disembodying process starts with the medicalisation of the donor into a patient as soon as they lie on the “trolley”.

Waldby and Mitchell (2007) postulate that tissue economies, which increasingly include emergent blood-related economies, are about the tense intersection of biological capacities and political systems of power.

The donated blood, when circulating outside the body, becomes in fact more important. It treats deficient bodies which are in need of its hidden powers. It is separated out in order to produce more power parts in the form of fractions of itself, e.g. factor 8, white cells, etc. Some of the respondents in my study understood this developing capacity of their donated blood, understanding the donation would be separated into parts and used for people with different problems; this was evidenced in what donors said. Doris, aged 48, interviewed in 2008, said that she understood that her donation was checked and then frozen and stored for future use. This is a very reductionist perspective, and the donated blood is seen as being packaged and put into a new form, different from that in which it was donated. Doris was seeing her gift being manufactured into some new product.

Other donors echoed this. Sue, aged 62, in 2009 said: *They check the blood and it's possible that it is separated into different components and stored till used*; thus further

bio-medicalisation of the donation. A further comment from Freda, age 39, introduced another aspect. The blood was, in her opinion, only good enough to use: *when it has been checked for diseases, then it can be used for testing and experimenting and then the blood is broken down to make it easier to give to those who need it.*

This concept of breaking down the blood, checking it somehow according to donors, seems to act to improve the blood donation in the natural state, and echoes (Lock, 2006 cited in Scheper-Hughes and Wacquant, 2006:71) the concept of the process by which body parts can become alienable, which is dependent on the part being conceptualised as thing-like. Donors in later sessions speak about their blood donation as thing-like rather than a gift, which was how earlier donors spoke. This, it is argued here, is illustrative of the impact on the body commoditisation processes, which are ongoing in current society.

So successful has the technology become that spare part surgery is “routine” in some hospitals, and this may now apply to the emerging concept illustrated here of “spare part” blood being a new reality. In reiterating Cassell (1976) we must not fail to note the moral fall out of this technological magic as it applies to blood, and identify new meaning and symbolism in an anthropological way. Several of my respondents reported that the giving of blood has become or is routine, so much so that it has ceased to be a conscious act. For example Sheila, when interviewed, said with regard to the process of giving blood: *It has been made to feel like a mundane event due to the factory-like impersonal way the NBS collects it – with no personal thanks to the donor.* To increase the statistically low percentage rate of the population that were givers, Sheila said: *I feel*

*they [probably referring to the NHSBT, but she was not sure] must try to make it more of a personal event for the giver which will trigger more social responsibility.*

Sheila is reiterating the way in which the whole process of blood donation is becoming dislocated from the giving body with the process becoming less personal. Some other donors said the same thing, for example Angel, aged 24, whom I met in 2008 and had donated 10 times, said *Everyone should donate, if they can, because blood is less personal than other things you can give like your eyes!*

This idea had resonance for another donor, as well as provoking examination of the self and body in relation to blood. Lisa, aged 61, was an experienced long-term donor who said: *I came to giving when I was younger and it seemed more individual then – more special. You had to really think deep into yourself to give.* Lisa is illustrating this change by saying that being a blood donator she felt that donating blood does not seem to have the same impact as it used to.

In interpreting these comments it is argued that blood is being conceived as being separate from the working body. This idea of separateness is evident in some of the accounts in this study, such as Ash who, when reflecting on the body as a form of human exchange, said: *Blood is different – it is like something you can take out and not notice – it's a replaceable part of you.* This is further illustrated by the testimony of Nurish, aged 27, who said: *When I give blood and I never think about it – now you highlight it. I am thinking yeah, maybe I shouldn't be so blasé – I mean all of me is in it, isn't it?*

This idea that “all of her” was in her blood resonated with the entire table group; it was revealing in that the majority of people do not give blood – and that those who do, do not think about what blood consists of. The discussion at the table was unusual as it provided insight into how donors see blood in related to their body.

Donors relayed information as to their solid organ donor status; it is from these statements and discussions that this part of my thesis emerged. By this I mean that set against the contemporary background of further medicalisation of blood and its components, the narratives from the donors interviewed seemed to develop the notion that the body has been made hierarchical to create a ranking order of parts of the self, both solid and liquid. The ranking represents which parts would be missed or which parts were “too special to give away”, the most special being related more closely with the concept of the self rather than that of the body.

This area of the fieldwork data led to theorising that a hierarchy of the self had been created to deal with the moral and ethical demands on the person due to the exponential medical need for all body parts. Increasingly blood donors feel that they “have to give something”, so they give what they think of as not being a part of them rather than electing to give away something else more central to their self

This introduces the notion of a hierarchy of the self, and related concepts of the inner versus outer self and a solid and liquid self, and in this new hierarchy blood sits at the bottom. Previously, it could be argued, donated blood was inalienable because of its ties to the self due to the larger unprocessed way in donated blood was utilised. My data introduces the concept of man-made blood, which may allow us to conclude that donated blood is no longer “inalienable” (Weiner, 1992).

For example one male donor, Nicky, aged 56, said in 2009 that he felt donating his blood was something which was: *Lifesaving to all; it is something I can easily lose but makes no difference to my body.* This implies that he felt no allegiance to his blood, but he understood that blood has more value out of his body than in it. Blood's value for the population, it seems, only occurs once donated. He was not the only one to express this view. Francis, aged 42 and interviewed at the same time, said in relation to his blood: *You know, blood feels like a consumable now. Even though it is fundamentally part of me, I know it needs to be taken to be given to others.*

There is a tension, it seems, with the donors distancing themselves from something that is fundamentally a part of their body in order for them to be at ease with the giving away of part of the self. This, it could be argued, is an example of blood donation entering the consumer market from some donors' perspective; an example of donors understanding the value of their body part rather than recognising the need for donating it as was the case in the past. This may be a key area for future research in blood, as there is a danger in people understanding the value of their gift rather than the need for it in relation to remuneration.

Another donor, Freda aged 39, saw her blood as being different to other body parts; she said: *Blood is different from other organs or tissues, as blood is safe from damage by lifestyle or of being of poor quality. Blood is also different because it is "replaced naturally".* Another donor, Julie, aged 38, expressed the view: *If donation takes place regularly it keeps the blood in the body of good quality.* This understanding of the blood as a separate as well as changing body part is linked to the notion that blood is represented differently in the hierarchy of the self. Donors' concern over the quality of

the blood donated is a further example of blood being reviewed as a separate, possibly saleable, body part.

This argument of biotechnical fragmentation discussed in the literature review relates well to the theme developed from the data, as the donors did not feel any association with their blood, not ascribing it with body part or fragment status, and thus not regarding it as part of the self. In other words, has blood itself become independently active and with a life of its own unrelated to the person from whom it came?

### **8.3 Alienation and the reordering of the self**

Interpreting the written, as well as verbal, comments by donors about comparing blood donation and donation of solid organs made me begin to think about how it is that donors come to the decision about what they would donate and what they would not donate, or “give away”, as some said. They rated their bodies and parts in relation to what they would think of as their self. This allowed development of a view about the body that I have termed a “hierarchy of the self”. This is because the donors seemed to have ideas about which were the main body parts that were related to the self and which were the parts that could be given away without any penalty or cost to the donor and the self. One said: *You don't notice it [blood] when it's gone*, and another said: *You can do blood donation when you are alive so you don't have to think about doing stuff when you're dead*.

One donor said of blood: *It is a bit like the heart. It is functional body part that takes oxygen around the body*. Another donor, Freya, aged 18 said: *In the past it was thought that feelings came from the heart and that it was where you felt things. Now we know*

*they [feelings] come from the head, so the heart is just like an engine and blood is a bit like petrol.*

The self had been put into a mental hierarchy by the donors, with some saying that blood was not important; as one put it: *You remake it anyway*. Others said that other parts were much more a part of you than blood, creating this idea of an “outer self” and an “inner self”. This fits in with the increasing biomedicalisation of the body, with individual parts of the body having their own existence separate to the body. Lock (1993:138) argued that there has been a new cultural construction of the self to take into account the fluid boundaries between individuals and society. This new cultural construction of the self in a hierarchy reflects this change.

The impact and changes on the self through the action of donation and the emergence of the inner social self can be compared to Goffman’s (1990) theory of what I now call the outer self. In the same way as the process of considering one’s self, the new body in society is being shaped by new technologies interfacing with separate body parts rather than interfacing with the body as a whole entity as was the case in the past.

Waldby (2002b) has also examined the impact of new technologies on what we understand as identity. How donors’ identities change in the role they play as donors has been discussed in the earlier part of the thesis

Sanner (2001), in an early investigation, studied public feelings and ideas about the position of receiving and donating body parts. Her studies have identified a series of patterns in attitudes to giving and receiving solid body parts, some of which have resonance for my study here and are discussed later in relation to the concept of a



hierarchy of the self. Her study identified that the body had become objectified and conceived as “machine-like” (2001:1494), whereby donors were happy to give and/or receive solid parts with a view that the body was a composite of interrelated parts rather than a body conceived as a whole. There were similarities in my fieldwork. Donors said that they were happy to give if it was for family or “proper use”, and the notion of receiving a body part or fragment seemed to be less well developed by my respondents from their narratives. Generally, the idea that a blood donor should automatically be a general organ donor did not seem to be the pattern.

Lock (2006) has written about this process of alienation of body tissue and bodies that has occurred within the blood donation area as well. She describes the struggle for ownership and control of the body by the state, and argues that the rise of biomedical control over the body, and later its extracorporeal parts, was embodied by the 1831 Anatomy Act. This act gave ownership of unclaimed bodies to the state. Increasingly, the representative of the state became the medical and not religious profession. The consequence of the rise of the resultant biopower (Foucault 1979) in relationship to blood and other body parts is discussed within this chapter with reference to this concept, as it is the biomedical demand for blood and more importantly its subsequent components that began the separation of blood from the self.

Donors seemed to understand this relationship between the state and their blood, demonstrated by Bill, 58, who said in 2007 that he understood that blood was needed: *Blood donation is a necessary social responsibility and I can't really understand why more than 5% of the country doesn't do it. It is just something you give without noticing. It just has to be done.*

A younger, female donor, Denis, aged 28, also felt that the state owns the blood in that: *Giving blood is a given, a sort of socially responsible thing to do these days. It is the sort of thing which should start at school, really, to get more of us.* These quotes from donors from different generations illustrate that the state responsibility has increased over time; Bill said it was a social responsibility, and the younger donor, Denise, said it was a given and that blood donating should be started at school age. The body part generation seem to understand that blood is a substance for donating without emotions attached to it.

Hamish, who had been donating his blood for 22 years, said that it was difficult to think about it being his blood now: *At first it was a good thing to do and it felt philanthropic, but now it is routine and mundane. Something I just do.* Here, Hamish is describing the process of dislocation, which allows the blood to be seen as not part of the self. Blood is therefore being located, for Hamish, at the bottom of the ranking order of the self.

#### **8.4 Alienation and the reordering of the self**

The data from the fieldwork examined which body parts are represented in the hierarchy. It also relates the process of blood giving to alienation theory (Weiner, 1992). Echoing this Shaw (2008), writing about the notion of gift in the donation of body tissues, suggests that the donation of body parts depends on the type of tissue donated. She argues that there needs to be more discussion on the rituals associated with donation practices. This argument has resonance for the theory presented here in relation to the different capacity and need accorded to body parts, as well as tissues, by my respondents. The lack of ritual accorded to the giving of blood is worth commenting

on. Although there are certain rituals with the process of giving blood, actual ritualistic signing over of the body part is not enmeshed in the rituals associated with the donating of solid organs.

The lack of ritual attached to the giving of blood is a metaphor for the lack of position blood commands in the hierarchy. Donors' accounts of how they feel about donating utilises mundane language, displaying a disconnection with the body. *I feel that hopefully someone else will benefit from my donation*, said one donor, illustrating that he feels no emotional attachment to his blood and demonstrating that it is not like the donating of "proper organs". The absence of overt ritual to recognise the giving of blood gives extra credence to my data gathered at what is arguably the only ritual evident in blood donation, the recovery table. It is the only place where any opinion and beliefs about blood can be gathered, which is why my project allowed insight and observation into the real world of donors in the UK today.

Waldby (2002:240) drew attention to the impact of medicalisation of body parts and the inter-corporeality transplantation and transference create. Blood is one aspect of this argument, as she argues that the market for health is mediated by what fragments of ourselves we can afford to give. One question, here, is related to whether donors considered blood to be a fragment of themselves or their bodies.

Only one donor reflected that there might be some link between themselves and their donated blood; no others did. Therefore, as the hierarchy related to the meanings attached to individual body part capital – which is created to allow these fragments to be freely given away – changes, then so does the position in the hierarchy. However, Waldby (2002:240) makes a good argument for blood within this commodity model

when she says: “To give an organ, blood, ova, embryos, sperm or cells is to be caught up in a social and embodied circuit in which the significance of one’s personhood imbues the fragment”. My argument is that the donors I met have placed blood outside this circuit; they did not think that blood was as much a part of the self when compared to other body parts that they could give away, especially reproductive tissues, breast milk and the face.

The impact of modern tissue and blood biotechnologies has, it is argued, impacted on what is considered to be the true self. This next aspect related to the aims outlined in the literature review is discussed below with particular reference to three body parts that caused comment: sperm, breast milk and the face. The work of Goffman (1963) was discussed in the literature review, and it is to this aspect of the presentation of the new “donor-self” that we turn. The self in relation to how donors present and manage the body which was in the past a body whole, now has to be presented as a “body-in-parts”. Sperm in particular, according to my donors, embodies the self more readily than blood, with one donor expressing that: *sperm is more part of you than blood*. Another donor said that he felt: *blood is not as much a part of me as my sperm*; thus, he was reviewing one body part against another, arguing that for him sperm was more part of him than his blood.

Other donors referred to breast milk as being a component of the body, writing it alongside heart and lungs in listing what they would donate or receive. They said that breast milk was more special than blood because it contained all the elements of mothering and that it was a special bond between the mother and the baby, therefore breast milk represented all the goodness of the body. Freda, aged 39, said that breast

milk had a mothering link which made it extra special, so she was uncomfortable about donating it if she was ever asked to.

A new, and to many donors fantastical, possible donor part was the face. Face transplants were mentioned by donors in 2006 because of the media coverage of the first face transplant.<sup>35</sup> The donors who mentioned it referred to the face as the “true you” and as an external self; people know you by your face. As a result it was considered the top of the hierarchy and something which donors who mentioned this would never donate.

Breast milk and the face were regarded as highest in the hierarchy of the self. This was indicative of their link to identity and individuality, whereas blood is regarded as a diffuse part that allows it to be given away without any concern for the loss or change in identity. This can be related to ideas of coherency in self presentation. Goffman (1972 cited Howson 2002:21) argued that we see ourselves as others do and share understandings of the expectations associated with the particular roles or encounters. The physical appearance of the body is central to the relation between virtual and actual social identities, but because blood is not visible, like the face for example, it is more easily given away. Huw, 18, (2009) said that blood is not part of his identity because: *the body is able to reproduce blood so it does not really feel like a part of me. I wouldn't give my eyes or face away because they are visible, nor would I want to receive somebody else's.*

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<sup>35</sup> [www.bbc.co.uk/sn/tvradio/programmes/horizon/broadband/tx/faces](http://www.bbc.co.uk/sn/tvradio/programmes/horizon/broadband/tx/faces)

Transplants and transfusion have become normalised through the medical systems that organise them. However, transference rather than transfusion of body parts carries, I would argue, a quite different argument. Helman (1988:15) in an early article chronicling the social impact of transplants argued that the impact of such practices has resulted in a “fragmented self” with the body “lacking coherence”. When this idea is applied to blood, it is possible to argue that the coherence of the self has become fragmented and blood is no longer seen as a coherent part of the self. This is due to the automatic replenishing of the part and largely due to the fact that you do not feel like anything has gone, as evidenced by those such as Andrew, 28. He felt that blood was just as much a body part as other organs and that: *You don't notice anything has gone, although inside you do, so this means you feel it has gone and make more.*

Respondent Sue in 2004 had been donating blood for 30 years. She did not see blood as part of herself: *It is just something you give, not like other things. It is just blood; you make up the loss in a few weeks.* She did not think that it was a social obligation to give solid organs but felt that blood was different in that everyone uses it, a different bit for a different problem, maybe indicating that blood was therefore an unspecific body part.

Helman (1988:16) describes this process as a “shrunk self”, but I would argue that rather than the self becoming diminished or smaller, it is or has been “reassembled” into a new hierarchy.

For example, Estelle introduced the idea of the “liquid self”. She said to me that she thought of blood as a sort of liquid self, with all the other liquid parts of the body, for example bone marrow: *liquid self –that is the difference –a bit like breast milk still part of you but different.* This idea correlates well with the different selves of the modern

body. It seems that the solid self is different from the liquid self, with the donation of a part of the solid self being more associated with donations after death. She was an experienced donor of blood, saying she had: *given 15 or so units and I think everyone should give blood if you are ok with needles and haven't got infectious diseases*. She said: *Donation is only done by 20% of the population*. Estelle was more interested in the whole idea of what blood means further into the interview. She thought about it and came up with this interesting and innovative concept of the self: *Liquid – that is the difference – a bit like breast milk. No one would give away their breast milk and yet blood is the same, really. I hadn't thought about this at all*. Estelle had not heard of breast milk being donated, and the blood donor sessions did not advertise that as well as tissues and bone marrow, that there is a need for breast milk donors.

The emergence of this new self, a liquid self, is interesting and relevant to issues about blood, the body and the self, for example in relation to the growing culture of body parts for sale. If the NHSBT were to become a non-voluntary institution, there would be serious ramifications for the ways in which the small majority of the population who give their blood free would see their product. We can related these findings to the work of Howson (2007:93) who argues that a key characteristic of the contemporary society is not only the emphasis placed on consumption, but this has had profound implications for people's sense of self. Beck (1992) further argues that we have become "agents of the self" creating a partnership with the new technologies and the self. Both of these statements have relevance here. This aspect of the thesis was developed out of comments by some respondents who were solid body part (i.e. organ) donors, saying that they did not consider donated blood to be still a part of what they considered

themselves or their body, either as it was being donated or when it had been bagged up and sent for redistribution.

Further, the cultural value of differing parts of the body for sale or “donation” informs us of the hierarchical regard for relevant parts of the body that different cultures hold, which is well documented (Sharp, 1994, 2000; B Turner, 1994). It invites investigation concerning the relationship between the body and the self in relation to the cyborg culture as well as the concept of bio or body capital in the consumerist society. Blood has reached a crossroad between nature and culture.

### **8.5 Man-made vs. natural blood**

Some of my donors expressed the belief that man-made blood was more important than natural blood, echoing Coleman’s (2004) assertion in the literature review that blood is more important now out of rather than in the modern body. They understood that the blood taken from them was broken down into “usable units”, whereas units in the past referred to an amount or a bag of blood. This new meaning implies understanding that blood has been broken down in its own “intra-blood units”, i.e. blood within blood. This part of the chapter analyses the way in which the public utilises extracorporeal blood, communicates the meanings attached to blood and examines what it is now understood to be “blood” with the construction of “man-made” blood in addition to natural blood.



The question of whether we see blood as a body part affects whether or not the need for regular “transfusions” would qualify the recipient as a cyborg.<sup>36</sup> Donors voiced opinions such as: *Once it is out of you it is theirs to do what they like with, and they bag it up and ship it to where it is needed.* This is descriptive of blood as a commodity that requires logistical control. The contrast when hearing about how recipients describe the process involved in getting a new heart or liver to the recipient is very different. The journey is an emergency, organs are transported singularly with reference and there is a vital time period in which to replant the part.

A central question posed earlier in the thesis was whether the donors consider their blood to be a part or fragment of themselves; because of analysis of the data for this chapter it is argued that they do not.

The disassociation of blood from the self allows the collection to be seen as an event that has significance at population rather than individual level. My participants related their bodily health to whether they had enough or too much blood, and therefore viewed blood donation as a form of therapeutic bloodletting.

The idea that it is necessary to periodically “let out blood” is still in the discourse surrounding blood; but this is associated more with bad blood like nose bleeds or menstruation, this being a form of natural rather than man-made bloodletting. For example Julie, 38, one of my informants, when donating said: *I do blood donation because I can, because it helps people. When I was a child I used to have a lot of nose*

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<sup>36</sup> <http://news.bbc.co.uk/1/hi/health/7958582.stm>

*bleeds, and obviously the body needed to give it [the blood] up. I sort of feel that the body needs to let it out ... Also, if the body is able to make it again easily it's probably better to have your body make some new [blood] rather than the same stuff circulating!*

This particular respondent was an echo of Titmuss (1997:300), when one of his respondents linked the cessation of nose bleeds to his blood donor activity. These illustrate the lay beliefs attached to blood in the body.

In this example, Julie is verbalising how her body is seeking this state of eucrasia by letting out the blood to allow refreshment of her circulation with fresh blood. Also, she is describing the blood as being allergic to an external substance which then provokes a response, and she has nosebleeds which tell her when her body is out of balance. Other informants gave a similar response. Andy said: *It is better for all giving it, but also I feel better when it is out – feels good for my health.* Another (female) donor said: *Sort of feels that it is the right thing to do, to let it out, you know – I always feel the same way after my period.*

One question related to this chapter which emerged from the data, is whether the donor is aware of their blood during donation. Several early respondents, who were interviewed in blood donor sessions at the recovery table, described the experience of giving the vital fluid and gift of life. One donor, whilst shrugging their shoulders in a dismissive action, not wanting to demonstrate too much physical relationship to the action of giving, said: *Fine; nothing really, a little woozy, then fine later.* Another described the experience, while looking around to see if anyone else was listening, as: *No change in normal feeling; I don't even notice it.* Another was dismissive of the question, shrugging their shoulders and replying: *Fine.*

These bland and dislocated statements can, it is argued, evidence the distance that blood has travelled from being understood as being part of the body, as demonstrated by James: *They make you feel comfortable so you don't notice it*. This respondent gives an insight into how the body itself may be “managed” during the process to make it seem that indeed you do not “notice it”. These neutral comments are, I argue, indicative of the process in that it feels almost like blood is not part of you. However, one respondent, Mandy, a female donor aged 26 who was a regular donor, did respond in answer to the question about who should donate blood by saying: *Everyone*. This donor then went on to say: *Even after its donation you wonder what happens to it*. In essence, blood has itself become active and “mindful” (Scheper-Hughes, 1987) with a life of its own unrelated to the person from whom it came.

## **8.6 Biopower and blood**

In Chapter 2 the impact and pivotal role of the Enlightenment and rationalisation of society was related to blood's relocation as the new target of power in tandem with the body. The body and blood, it is argued here, increasingly became the new vehicles through which the new life-giving concept of bio-power was mediated. The concept of Foucault's (1977) biopower has become focused on the regulation of the population via hegemonic biomedical surveillance. This notion can, it is argued here, be extrapolated to micro-societies such as the blood donor fraternity.

Rabinow and Rose (2003) relate “biopower” to Foucault's biopolitics role in investing life through the social body. The Blood Service itself may be regarded in this respect as “a great technology of power” and especially so since, unlike other organs, blood has

the capacity to regenerate from any loss. This increases its power and the need for social control over it. The blood-giving population actively works on itself to provide and re-provide blood from their bodies. Coleman (2004) highlights to us the power of the body in relation to blood donation; being a regenerative body part blood has an external economy or currency to the body economy of its host. The asset becomes even more powerful a biological product if the type is rare. These ideas have relevance for the notion presented here that, because of the relationship society now has with the body, its relationship with blood has also necessarily altered and resulted in the objectification and subsequent alienation of blood from both the body and the giver.

Douglas (1996) has highlighted that there is a reciprocal relationship between the social and bodily experiences as both symbol, and a conduit through which life is experienced. The body is also a metaphor for the relationship between bodies and society. Durkheim's (1893 cited in Giddens, 2006:9) organic metaphor fits with an analogous notion of one blood circulating in individuals but as a resource for society, so blood has developed its own relationship with both the body and society, in essence a "social fact". Blood has come to represent the organic rather than the mechanical solidarity at the time of the NHSBT inception.

The mind and the body have been considered as mutually exclusive within the medical world, and the emergence of other bodies as communicators of human social action is part of the process of re-examining what is meant by both the "self" and "body". Moreover, we should now investigate how this may relate to the present relationship blood has both to the self and the body.

The ability of modern medicine to rebuild bodies using new technology, “spare part surgery”, and to an extent the notions of new reproductive technologies invited a reassessment of the body and the self. These ideas and reassessments of the body can be extrapolated to blood and the new blood “spare part” components. Blood has also developed its own market price as well as having genetic value. Research by Dickenson (2008:18) in relation to the phenomena of “body shopping” presents evidence that there is a price hierarchy for the body, with the price of a whole cadaver being set at nearly ten times more than a forearm, for example. Of course, blood is not for sale, collected as it is via voluntary donation here in the UK. However, Starr (2002) has argued that the present real price of human blood is more than crude oil. Because blood is not for sale in the UK the market price is difficult to ascertain through testimony, but it is possible to infer the importance of genetic material from testimony concerning which body parts are rated higher than others, for example sperm versus blood.

This is described by respondent Inger, interviewed in 2007, who was a 68-year-old female. She was the longest-serving donor (45 years!) and had been the recipient of various thank you gifts over this considerable timeframe, including pens and badges. She was of the opinion, even after her long period of donating, that donation of body parts, tissues and body fluids, including blood and bone marrow, should be a voluntary process. She strongly disagreed with the sale and commoditisation of both solid and fluid body parts. She felt that blood should be treated in a different way to the other body fluids and parts as: *No obvious change can be seen in the donor. The recipient has no external changes apart from feeling better, we hope.*

Another donor, Freda aged 39, contributed to this aspect. She was an “old timer”, saying: *I have given blood more than 30 times*. By this, she meant that she had donated many times. This established her as a senior donor and she was confident in her contribution to the research station. She went on to say: *I started when my ex-husband wanted to do something different and he surprised me by saying that we were going to give blood. Now I have been doing it for so long it is just a routine, even though I hate it!* She was okay with the donation of tissues and factor 8 from blood, but after thinking about it she did not agree with sperm donation. She was happy for blood to be reused for blood platelets. Therefore, Freda had put blood somewhere different in her hierarchy of what was okay to give away, together with restrictions due to ethics on reproductive organs, sperm and eggs.

Freda listed out her parts that she was not going to give as being cornea and, interestingly, breast milk. She explained that breast milk was special to her: *because breast milk is linked to mothering, not for what is in it*. When asked if she had considered why blood was different to other donated body parts, she answered: *Yes, blood is different to other organs. Tissues and body parts can be damaged or of poor quality*. She went on to say that the damage could be *self inflicted* or *due to health reasons*.

The ability to rebuild bodies and therefore the “self” using new technology plays havoc with the notion of bodies and selves. The cultural value of differing parts of the body for sale or “donation” informs us of the hierarchical regard for relevant parts of the body that different cultures hold. It invites investigation concerning the relationship between the body and the self as being something to do with personhood. One of my

respondents, Julie, presented a metaphor for a new self, created by the action of blood giving. She was happy to give more of herself in the form of solid organs; however, she also said: *But I haven't got a donor card.* Julie talked about blood and the body, saying that she thought that blood was definitely: *different to other parts of the body and easier to give than other bits, so more should do it.*

Graham, aged 67, whom I met in 2006, thought that blood was not a proper body part, as it was only temporarily part of the self and that at his age he could not think about receiving another bit of someone else. By using the word temporary, Graham had opened up this debate about where blood lies in the hierarchy of the self even wider. No other body part could be described as temporary in the same way, illustrating the difficulty in placing blood in the new biomedicalised self.

Angela, a female respondent, carried a donor card for solid organ donation but had never been a regular blood donor. On reflection, this surprised her as she said: *Seems a bit silly to say you could give one thing away you couldn't get back, when giving blood means that the amount donated is replaced; after a very short time it is like you never lost it. It's not really a real part of you till you actually see it; it is the last thing you worry about packing up.*

The use of metaphors has been described by Kirmayer (1992) to highlight how we use other keywords and phrases to convey meaning about our self and body. The cultural value of differencing parts of the body for sale or “donation” informs us of the hierarchical regard for relevant parts of the body which different cultures hold.

Sharp's article (1994), which examined the transformative impact on the self following organ transplants, argues that although much literature on post-transplantation recovery exists, it fails to examine the salient feature of the effect, i.e. the subsequent reorganisation of the old self to reside in congruence with the new body. Reorganising one's new self is a problematic event for the recipient despite the biomedical success in the physical process, i.e. the potential of rejection. In a paradox often found in technological advancement, medicine may have saved the body but harmed the self. The problem with the existing paradigm of mind–self–body being mutually exclusive is to some extent dependent upon the cultural worth of the body when dead. In the West, it is regarded as impotent or lacking the components of the “self”; however, Helman (1992) has described dead bodies in autopsy or other situations being regarded as people. This may have to do with the perceived sanctity of the human form rather than the intrinsic belief that the self remains “embodied” after death according to Scheper-Hughes and Lock (1987).

The contemporary notion of “wasting” potential donor parts is not a feature of all cultures, some of which revere their dead and do not violate the memory or “cultural self” for the sake of organ harvesting, for example in Japan (Lock, 2002:5). Further, Sharp (1996) argues that the notion of personalised body parts as in Cassell's (1976) paper, which was referred to earlier in this chapter, is not as preferred as the concept of “organ as a thing” and therefore blood as a thing. What is interesting is that even in the home of biomedicine at its extreme, not all states agree on what criterion is required for determining death. Sharp comments that the language used around the topic of donation sets out to depersonalise the “parts”, to overcome the problem posed by those who do



follow Cartesian dualism. My donors did depersonalise the blood; they called it *the blood* or said *it is only blood*.

Evidence is gathering to suggest that donor families believe that despite the physiological death of the body, a life essence or “self” lives on in the recipient. Sharp cites studies that comment on the problematic sequel surrounding transplants, whereby the kin seek a lasting relationship with their relative’s new body, e.g. Fox and Swazey (1992:34–45). Beidal (1987 cited in Sharp, 1996) has argued that recipients agonise over the possibility that they will “become” the donor or at least acquire their qualities, positive or negative. Veidermans (1974) cited Sharp’s (1996) informative study of racist concerns whereby it was imagined that the white woman recipient would “reject” the black body part of the donor. Donors of blood do give their blood a life once it has left them; they even hope for a good recipient as demonstrated by one of my donors, Mandy, who really felt that blood is part of the self and even spent time after donating it wondering what happened to it. She was wondering where it had gone, rather, to whom, which is illustrative of the change I argue has occurred, that her blood is inalienable.

In an effort to arrest attachment to the body part, transplant ward staff will reduce the organs to purely a functional quality. Healthcare workers focus on the altruistic nature of donations in general to desensitise the issue. Sharp (1996) argues that recipients reform or transfigure their own “self”. This, if ever happens, can take a long time. Sharp cites the case of the “kidney” which still has not been fully accepted by the recipient’s “self” fifteen years following the transplant. The result, according to Sharp, is that the organ, donor and recipient integrate in a Gestalt fashion to form a new self, something not wholly congruent. What would occur, should the organ fail, would be possibly a

schizophrenic episode for the recipient, as surely the failed body part would not be regarded as the self; a renegade self at best. A further complication of the donor–recipient relationship and the notions of body and self must be the development of mechanical organs, such as hearts.

The transplant arena is the most salient arena for the discourse surrounding the body and the self, for two things occur to the self of the recipient following the transplant; the dependence of the self on someone else, and the continued dependence on medicine to continue the new “self”. In a way, autonomy is sacrificed for the chance to live a life.

## **8.7 Giving and receiving**

Sanner (2001:1494) studied public feelings and ideas about the positions of receiving and donating body parts. Her studies have identified a series of patterns in attitudes to giving and receiving solid body parts, some of which have resonance in my study here and are discussed later in this section in relation to the concept of hierarchy of the self. Her study identified that the body had become objectified and conceived as “machine-like”, whereby they were happy to give and/or receive solid parts with a view that the body was a composite of spare parts. I have found similarity here. Gail, aged 28, whom I met in 2009, said that she would not donate her face, neither would she be comfortable with receiving skin or face, because the face is visible and forms you – your personality. Barbara, aged 49, in 2009 agreed, saying: *They can have everything else, not my face; and if I needed it I would take everything.* When asked if this meant including face, she was unsure. This new body part for transplant added to the discussion around the recovery table as a result of the face transplant referred to earlier in this chapter.

Sonia, aged 54, said: *As yet I have not agreed to donate any of my other parts, as I haven't been able to come to terms with this; if I needed things like eyes, cornea and heart, I would, even though I have just contradicted myself!* Sonia is illustrating the tensions in society concerning the donating and transplanting dichotomies. It seems hard for people in my study to come to terms with the body in parts, even though by being an active donor of a pivotal body part they are contributing to the world of transplant, transfer and transfusion.

Another attitude pattern reported by Sanner is the mixed feelings regarding the willingness to give, with a clear preference to give to a family member. This is another attitude pattern observed by Sanner (2001) and found in my study. This idea that the body is objectified can be extrapolated to some views voiced by my respondents. Family ties were a feature of many of the answers linked to giving and receiving body parts. For example, Clive, interviewed in 2006, said: *I would only donate to close friends or family, you know those who would need something particular from me – my body.* He reviewed this again and reaffirmed this decision by saying: *No, I would only be happy receiving from family.* He presented the notion that family bodies are better to receive from, that family parts would be a better match. Whilst this is sometimes true, it is not always the case.

The growth of modern medical capability in the area of transplant has, in its turn influenced the Western biomedical concept of the self and the accepted model of mind–body dualism. These advances test modern notions of body and self, both in the immediate and long term. Further, the multi-culturisation of all societies and the role of

the media mean that the cultural differences of old may not persist. The body is not just the self, or vice versa.

Another area to problematise has been to analyse how much of the self is given when donating body fluids and whether there is a hierarchy attached to differing body parts and soft tissues versus solid organs. Defining yourself through your body is increasingly something that Western people do. We see the self portrayed as fat, thin, etc., and constant discipline is directed at the body to keep it in shape (Bordo, 2005). This reinforces the Foucaudian (1977) gaze being centred on the self as outlined in the Literature Review as a major social force which shapes people's reaction to and involvement in body modification as well as commoditisation. This idea of body and personhood can be identified by examining what relationship people have with their own blood as well as their own body. We can see a corollary, either discipline being applied to body parts, especially blood, to enable their redistribution. Blood has to be disciplined as well as the host. This was evidenced in the narratives of the donors in the preceding chapter who were concerned that their lifestyle was not good enough for donating their blood.

The respondents talked about what part of their body they would not give and whether blood was part of the self. The excerpts have illustrated the idea presented here of an emerging hierarchy of self in relation to giving body parts. Nancy did not wish to donate her heart and lungs but did not feel she could say why. She felt that donation of body parts was not a "social obligation"; the family owned the body of a person after death and that the body parts of a person should not become freely available to others after death.

Clearly people are concerned with who gets a piece of them, and, in the light of a variety of reported transgressions of power by the medical profession in recent years (the Alder Hey scandal as highlighted in both the ethical section of my methodology chapter and in the introductory chapter), this custodial watch over the body seems to appear in the literature related to certain body parts such as sperm, for example (Tober, 2001 cited in Scheper-Hughes and Waquent, 2006:138).

The similarities between sperm and blood are cogent for this argument of hierarchy. Blood and sperm have certain parallels. They are both body parts with the capacity to regenerate, both can be donated and stored, both have the capacity to be seen as a gift of life as well as a carrier of disease, and both can be seen to be either mechanical or life giving. What is really salient is that they are both regenerative and transferable. This makes them different from solid organs. The fieldwork carried out by Tober (2001) examined views and perceptions from potential donated sperm purchasers on what traits were perceived to be in sperm. Her informants transferred the search for a partner into the search for the sperm to be the carrier of all the physiological genetic attributes and the potential of personality-related attributes. This is illustrated in Martin's (1991) study of donor sperm users: "We wanted someone bright who drank coffee (like the couple did), so that if we met him (the donor) we would like him". Svendsen (2007:22) presents sperm donation as a practice of relatedness. In ethnographic fieldwork in Denmark, Svendsen (2007:27) also looked at couples receiving embryos, looking at how the medical language presented the body part as being good enough or considered as waste, and how one couple ascribed the quality of being "good looking" to the embryo. My study included a few male respondents who endowed their blood with masculine qualities when talking about it: "strong" and "rich", for example.

## 8.8 Natural and man-made blood

It also became evident that there must be a concordant corollary of differences between types of blood. For example, I argue that there has been a division of blood into natural blood and what I would call man-made blood. In the literature review I alluded to the processes of McDonaldisation being applicable to the blood donation process. The following is an example in the fieldwork. The donor helpers and nursing staff at the sessions I attended were describing this bureaucratisation process. For example Sue, one of the early informants, said in response to my surprise at so many people coming to donate: *It's just a numbers game now. We have at least 150 to 200 each day and evening here if they all turn up, that means we have to get them all processed and bagged up before we can go.* She also referred to the continuous targets she was set about the time it took to process a donor: *They want them in and out as fast as they can.* This can be argued to represent the commoditisation of the blood, but also of the donor.

Table 2, shows the divide, natural blood being blood in its virgin whole state, with other sorts of natural blood such as menstrual blood and nasal blood.

The classification of non-natural man-made blood has emerged via the medicalisation of natural blood, and includes many more types of blood than natural blood. Man-made or manufactured blood includes factor 8, plasma, packed cells and clotting factors. Several respondents were aware of these two types of blood, especially the younger donors who automatically understood that some of their donation would be used for research and producing blood products.

Some of my donors expressed the belief that man-made blood was more important than natural blood. They understood that the blood taken from them was broken down into “usable units”. Units in the past have referred to an amount or a bag of blood. This new meaning implies understanding by some donors that blood had been broken down in its own units, plasma and gamma globulins, for example.

<b>BLOOD</b>	
<b>NATURAL</b>	<b>MAN-MADE</b>
Whole blood	Factor 8
Menstrual	Cell line
Nasal	White/Red cells
Wound	Plasma
Umbilical cord blood	Platelets

**Table 2: Blood: Natural and man-made**

The concept of “unnatural uses” of blood is one that this project has set out to interpret. Blood used immediately to save a life is seen as natural, rather than the use of blood to save lives by the unnatural use of each component of blood. This is an area where it is argued that blood has been relocated out from the actual self into wider society. An example of this is the 2002 project to salvage more blood lost during surgery in order for it to be used again.<sup>37</sup> The impact of global telecommunication via the World Wide

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<sup>37</sup> 2002 HSC “better blood transfusion cell salvage during surgery”.

Web is particularly pertinent to the concept that human blood is a socially shared fluid in the name “Blood UK” (2002). And in that of other countries, the Blood Service has evolved institutionally and functionally in society.<sup>38</sup> From being a by-product fragmentary service, the institution has undergone many statutes and Department of Health (DH) Directives as the Service becomes ever more accountable to the key players involved, i.e. the public and biomedicine. The DH Directive “better blood transfusion” has relevance to the Service’s position of trust and honesty (Titmuss, 1997). Also within this debate it is the “waste of blood” that is an issue within the management of blood. By management in this context is meant the recycling or mopping up of blood spilled or not used during operations.

Thus transfusion becomes a speciality in biomedicine, leading therefore to the medicalisation of volunteerism. Donation of blood becomes a service, both to biomedicine and society. The blood transfusion service as an institution has changed over time since its inception. Demands on the Service have led to more “unnatural” uses of the donated whole blood. Copeman (2005:469) turns to this theme of blood management, as it is pertinent to the concept of blood as a gift. What happens to blood after its gifting is interesting. Pooling of whole blood donations at once dilutes the gift (Derrida, 1992) and increases the risk. On the other hand, it increases the productivity of blood as a market product.

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<sup>38</sup> [www.americasblood.org](http://www.americasblood.org)



The separation or “hierarchisation” of the self into a new organisation of self via the body is evident within the testimonies. The separation out of, for example, sperm in particular caused me to think about a sort of hierarchy of body parts with some parts being viewed as purely mechanical and others as life giving or linked in some way to special qualities, e.g. manhood or individuality.

Bob, interviewed in a session in 2005, a 52-year-old manual worker who was from a local office supply factory, commented: *I felt that everyone should donate blood, body parts like heart, lungs<sup>7</sup> and bone marrow.* However, he did not feel it was right to donate sperm: *I couldn't say why I separated this out – just a different type of body part.* He thought that of the possible population who could donate their blood only about 15% did, and that this was: *leaving it up to a few to support the rest in time of need.* When asked as to why he donated he said: *It feels like the right thing to do and it is a social responsibility.* He felt that he would donate all the organs he could but not his sperm, as it was special to himself as an individual, whereas blood was more diffuse. He was describing two levels of the self here. He also felt that if it were required, he would be happy to receive all forms of transplantable parts. This interview was in a public area, and therefore the discussion about this interesting area was curtailed. This feature has been seen in earlier donors. In relating this respondent's answers to a hierarchy of self, he felt that he was happy to receive a full list of body parts as well as blood when he was in need.

A donor who did write on the interview form to indicate that he was willing to donate sperm was Paul, a 38-year-old donor who gave no details about how long he had been donating blood. Paul was reserved and, although happy to fill out a sheet, he was not

expansive when interviewed. He felt that it was a *personal choice* to donate blood and other body parts. He did not exclude sperm from this in contrast to other male respondents and said that blood was a small part of a person as it was readily replenished. Colin was also interviewed as part of the later 2005 group. The donors were able to talk to me as well as fill out the questionnaire. Colin was 51 and a very regular donor who was very much in favour of everyone donating blood, but he felt that other body parts and solid organs' transplant and donation was *up to the individual*. This applied to sperm as well. He was well aware of the small percentage of donors; he put the number at: *less than 20%. Not everyone is aware of the need unless something happens to them*. Colin felt he was doing the right thing by giving his blood, but he also added that he was keeping himself healthy enough to give. He was committed to the whole aspect of donating: *It is the way it is going [healthcare]; so no, there is no part or fluid I wouldn't give [laughing at the reference to breast milk]!*

Lisa, aged 61, was at the same session as Colin and the interaction of the donors ensured that more free thoughts were expressed. Lisa was of the opinion that blood donation was a personal choice, as was further donations of other parts and tissues. She said that only 5% of the population donated their blood, which was a very accurate estimate. She felt that by continuing to donate she was doing the right thing, and added that, on reflection, she did not know what motivated people these days.

Even females reserved sperm as being something special and ultra-individual, in contrast to other parts of the body. Amberley was a 23-year-old female. Her reply to the question of should everyone give blood was once again linking the obligation to the ability or capacity to donate, morally and physiologically: *Yes – if they are physically*

*able and have no religious objections.* She felt that there was no distinction between donating blood to that of other solid body parts: heart, lungs, eggs and bone marrow. However, in relation to sperm she said: *Not sure*, again endowing this body component with different meaning.

Amberley was able to say that 5% of the UK population donated their blood (this is an accurate percentage). She said she donated due to her feelings of *social responsibility*. She herself would not donate the newer components of the body such as tissues, breast milk or skin. This was due to their personal relevance. She further highlighted that she would not receive eyes, tissues and skin. This was because: *I would not feel comfortable with other people, unless, if it were life or death, I think I may think differently. The reason blood is different is that it seems unrelated to you when you give it, and you don't physically notice that anything has gone.* Amberley here is saying that her blood is almost a separate body part and, as such, not high up in the hierarchy of the self, which is headed for her by skin, tissues and breast milk.

Doreen, a female aged 51, was an excitable donor at the normally quiet table. She was interviewed late in 2005 and was a donor of a few years' standing. She felt that everyone who is "able" should donate. This notion or perception was the subject of the preceding chapters. She thought in relation to body parts that all the population should think about giving or organising the giving of body parts like the heart, eggs and bone marrow, and she also ticked sperm. This is different to the male respondents of this question, who, on average, treated sperm as a different form of body part. The estimate she gave of the donating population was: *Probably not as much as 50%*. In answer to the question as to why she donated, Doreen speculated that she was: *doing the right*

*thing for those in need and for everyone in general. She said that she would get involved in solid organ donation: Only if it was useful would I give it.*

This was linked to a perceived reduction in usefulness with age. When Doreen was considering her reply to the question concerned with those parts she would not give, she said that she was not happy to donate her skin. When asked if she knew why she had excluded skin she said: *Not really – just skin is on the outside.*

Therefore, in the modern world we are voicing a sort of hierarchy of our selves. Doreen has created a hierarchy of herself which includes an inner self and an outer self. For her, skin is part of the outer self that she is not happy to give, even though the technology is available and it would help as many unhealthy or sick people as blood, for example burns victims needing a skin graft.

June, a white lady aged 38, did not want to share how many times she had donated. I surmised that this was because she felt it too private or revealing, which demonstrates the private nature of the emotional labour of the donor. June felt that the work of the donor was both a private and a *personal choice*. She would be happy to give or receive all major body parts with the exception of the face and, again, breast milk. She was very interested in the idea of donated breast milk: *I know it used to happen in the past but I can't believe they can do it now what with all the restrictions. Look what they do to you to let you give blood!* This sparked off a discussion with another donor who was sitting close by, and she mentioned the milk bank in Oxford. June went on to say: *Milk is special because it is something a mother gives her child. It should not be given to anyone else's. You get part of your mother that way. It is even more special a gift than blood.*

Therefore, for June the hierarchy of self with regard to what was being given away had the face and breast milk higher up than blood. This is possible evidence supporting the notion that blood is disembodied and is located at a lower order in the “self” for donation in relation to the more traditional transplant and donation of body parts in the past, such as heart and lung. The hierarchy which donors create is related to their self as a person, not their body, although further research in this area would be useful in confirming or refuting the idea of a hierarchy of the self which I am proposing here.

Bob, a male aged 47, did not reveal how long he had been donating for. He felt that donating should remain “a personal choice”. He said that only 18% of the population donated and that: *Blood is a very important part of oneself. Consider the general emotional reactions to the sight of blood.* This was very interesting, as no other respondent had hinted at emotions attached to the sight of blood, except for one donor, Paul, who did when talking about the media and blood in films (see section on media in Chapter 7: Giving to Get back: From Altruism to Covenant).

Clive, a 28-year-old male donor, was a regular donor and was keen to comment. He answered the questions as to whether all people should be donors by saying only if it did not affect their health. He felt that: *With all the restrictions on blood only around 4% of the actual UK population donate.* This, he felt, made it: *even more important that those who can do.* He was not interested in the donation of other body parts, and especially sperm. He felt that donating blood was more than enough. He said: *Yes, blood is part of the self.* His reason for donating blood was to make a difference and help others.

As well as this stated reason, he also ticked the box to indicate that donating was a family tradition. He had a strong family link with parents and siblings. In line with his earlier comments about donating only blood, when asked if there was any organ, part or fluid he would not donate, he replied: *I would only donate to close friends or family in need of something particular from me.* He went on to expand this distinction, by arguing that to give or receive from other than a close friend or relative would be “morally wrong”. He reviewed this again and reaffirmed this decision by saying: *No, I would only be happy receiving from family.*

Graeme, a 28-year-old male, felt that all those who are *able* should give blood. His feeling about posthumous body part donation was that he was: *fine about it. But I can see why relatives mind about the body being cut up.* Despite his acceptance of donation, he was not okay about donating his sperm: *That is a personal choice. I wouldn't feel comfortable myself.* He felt that only 5% of the population gave blood. He listed his reasons for donating by saying: *I think that blood is something so easy to give that can help so many.* He was alluding here to the power of blood once donated. He was of the opinion that once he was dead all his organs could be used, saying emphatically: *Go for it!* In return for his generosity, he felt that the reciprocity should be there in the form of organs being available for him if he needed them. Thus, he was seeing donation as a form of societal exchange.

Even those donors who commit to public body sharing by being active in donating blood want to keep another, newer donatable body part out of public circulation i.e. sperm. Gary was a 39-year-old male donor at the sessions. He felt that everyone should donate: *Yes, it should be compulsory.* Further answers revealed that he was a bone

marrow donor for the Anthony Nolan Trust. He was estimating that only 5% of the UK population gives blood. Despite his being a committed donor, Gary was definite in his saying that he would not donate his sperm. Gary thought that blood itself was part of the self, but he questioned that maybe sperm was: *a more important part?* Gary believed that he donated because it was: *the right thing to do, and latterly it has become a social responsibility.* He had not been a recipient of blood in the past and he did not mention family connection. He would donate heart, lungs, liver, tissues and skin. When asked about himself receiving various organs, he felt that it was: *dependent on their state.*

The similarities between sperm and blood are cogent for the argument of hierarchy. This separation out of sperm is interestingly causing us to think about a sort of hierarchy of body parts; some are viewed as mechanical and others life giving (see Table 3).

<b>MECHANICAL</b>	<b>HUMAN</b>
Heart	Egg /ova/milk
Lungs	Sperm
Liver	Blood
Kidney	Eyes
Skin	Face
Blood components	Limbs

**Table 3: Capacity of body parts: Mechanical and Human**

The donors who recorded any thoughts about this aspect divided body parts in this new binary framework of mechanical and human. Hearts were mechanical and those body parts which were especially human were sperm and breast milk. This was because they were perceived as carrying what was termed “the true you”.

This is more than a hierarchy of body parts; it is a developing hierarchy of self in relation to the giving and receiving of body components. This leads to the question of whether some parts of the body belong more to the self than others. Some parts of the body have been linked to being a sort of waste product and not part of the real self.

One example of this is the umbilical cord blood. Considering its location and relation to new life and regeneration, this seems a little odd. Waldby and Mitchell (2007:110) have examined the journey that one so labelled blood-related waste product, umbilical cord blood, has made. They argue that this type of blood has been reclassified as “a significant fragment of the infant”, whereas it had [formerly] been classified as “waste product”. This part of blood has been reclassified largely due to the further technicalisation of the body, as technology finds new ways of utilising once discarded parts; such is the need to utilise all parts of the body carcass. This proves that the body has a hierarchy and that positions within it are subject to alteration depending on culture and technology as well as the market place. The therapeutic value of cord blood has been realised to treat bone marrow disorders; it contains the “pre-blood” which can assist in the recovery of bone marrow. Cord blood, as it turns out, is more immunologically flexible than bone marrow, and therefore its transferability increases, making it potentially very valuable and marketable. This creates a dichotomy for the donor.

## **8.9 Conclusion**

This chapter has used ethnographic material to exposit the understanding of social changes in blood donation in relation to the body and the self, which, it was argued,



represent a further pertinent concern about donated blood and the body in society in an increasingly biotechnological world. The aim of this chapter was to draw on the previously stated changes in blood donation to focus on the body and present data about how donors view their gift in relation to their body. Donating blood is no longer a gift as there is social pressure to give, i.e. donors are under duress to donate, stopping the donation being a gift. The social pressure is illustrated by the over estimation of the proportion of the population that donate. Whereas as a few estimated correctly at c.5% many thought that donation levels in the UK were at the 20% to 30% level. Furthermore blood donation can be considered not to be a gift as donors are giving to get back, either for themselves or their family and/or friends. In addition, the chapter analysed the way in which the public utilises blood and communicates the meaning attached to it. It also examines what it is that is now understood to be “blood”, with the emergence of what I call “man-made” blood and its being added to “natural blood”. This incorporated a discussion concerning “biopower” (Foucault, 1990) and how this concept relates to late modern blood donation.

The impact of biotechnology on blood has created a secondary market for blood components and latterly fragments or parts of the circulatory system such as umbilical cord blood, which was considered a waste product in the past. Moreover, the biotechnological advances have created a tension in the inalienable potential of donated blood, as increasingly the donated blood is processed into parts unrecognisable and critically unrelated to the original donated blood and donor. This has led to concepts of disembodiment of blood and the creation of man-made or synthetic blood (McBlood).

The rise of biomedical technology, especially in relation to donation and transplantation, is influencing the concept of the individual. Ownership of the dead body is increasingly being returned to the state. Contemporary society has to regulate its bodies via the 2004 Human Tissue Act.<sup>39</sup> It has been argued here that the rise of surveillance medicine (Amstrong, 1993) is indicative of the rise of theories concerned with viewing the body and its products as being morally obligated, to be shared and protected by all society. The impact of these techno-medical capacities on the secondary market for pooled human blood has created a dilemma for the donors in the UK. They have been socialised into regarding their donation as a unique gift, rather than raw body part procured for refashioning and recirculation within the public arena, with no regard or link to the donor from whom it came. The social pressures and the technicalisation of utilising blood in man-made components involved in donating of body parts has, it is argued, led to the creation of a hierarchy of body parts with blood at bottom and sperm at the top, liquid self being less important than solid body parts and the inner self being less important than visible outer self. Blood, it has been argued here, has slid down to the bottom of a self hierarchy, which is indicative of how the majority of my donors viewed their blood in relation to other more significant body parts such as the face, breast milk and sperm. The final piece in the jigsaw created here is to juxtapose these feelings of inalienation with the late modern requirement, which is, as one of my donors said: *You have to give something of yourself these days.*

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<sup>39</sup>[www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4103686.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4103686.pdf)



## **Chapter 9 Conclusion and the Significance of the**

### **Findings**

This concluding chapter acts as a summary of the research aims and findings and highlights what the thesis has challenged and added to our knowledge of blood donation. The original title for this thesis was “Blood as Cultural Symbol: Altruism and Giving Reassessed”. However, the project widened out into other aspects to include the relationship between blood, the body and society; hence the evolution of the title and scope of the thesis. It has become apparent through the duration of this study that the donation of blood is more complex than it first appeared: blood and its donation in contemporary Britain needs, it has been argued, to be understood through theories other than altruism which, according to Titmuss (1997), was the dominant paradigm through which blood donation could be explained in the 1970s and ever since.

The aim of this thesis was to explore the motivation, rationale and justifications for blood donation in contemporary British society in relation to the prevailing paradigm of altruism, and to look for new ways to understand and conceptualise the public action of voluntary blood donation. These aims and objectives have been met. The purpose was to re-examine giving blood as a solely altruistic event and the consequent relationship between blood as part of the body and contemporary risk and biomedical surveillance

culture and relate this to background theoretical concepts in these areas. The thesis has achieved its' objectives by exposing and challenging the framing of becoming and remaining a blood donor using the altruistic paradigm as being limited and one dimensional. As a result a number of new theoretical questions relating to the meaning and interpretation of blood donation have been raised and this thesis has demonstrated that other concepts and theoretical analyses, such as theories concerned with risk, citizenship and the increasing impact of surveillance society on the donating body, need to be added to our conceptual repertoire if we are to make sense of blood donation in contemporary Britain.

This concluding chapter will reflect on the chief findings of the thesis. It will demonstrate the significance of the findings to argue that it has provided a new understanding about the theoretical underpinnings of blood donation to both medical anthropology and the sociology of the body. As stated in my introductory chapter, the body and now blood are increasingly the foci of both anthropology and sociology; as a result this thesis can be construed as of interdisciplinary value.

Finally, this last chapter will discuss the significance of the study's findings for future research. First, however, each of the chapters is précised to provide a reflective and connective overview of the thesis.

## **9.1 Overview of chapters**

Chapter 1, "Introduction", served to introduce and set out the rationale and objectives of the thesis and provided an overview of the content. It related the objectives of the research to existing theory relevant to blood donation.

Chapter 2, “Historical Context – The Rationalisation of Blood: Blood as Science”, was my idea of an anthropological interpretation and a chronicle of blood transformation from being a bodily humor and the impact of the technological innovations from the early Enlightenment period. It attempted to ascertain the impact of the immense social, biomedical and technological changes which were instrumental in transposing blood from a symbol of religious connotation to become a symbol of biomedical management. In particular, it positioned the work of William Harvey at the centre of the shift, highlighting the changes in the understanding of how blood circulated and how this new knowledge acted as a catalyst for change in how the lay, as well as emergent medical professionals, understood blood and its role in the new social body. It further provided reflection and analysis concerning the transition of blood from being a mythical life force to becoming a literal and visible potent, life-giving and life-saving substance, for example through the work of James Blundell and Karl Landsteiner. The new miracle of blood was transposed via medical discoveries such as the use of anti-clotting agents (e.g. sodium citrate) and the rhesus antigen, which served to consolidate the new power of blood management, because they facilitated forward planning of blood transfusion and led directly to the setting of what became the voluntary National Blood Service, which were the object of Titmuss’ and my own investigation. This chapter allowed the application of the theories of biomedicine to blood and blood donation. Moreover it allowed reflections on how blood donation may have been linked in error to attributes of altruism in the first instance. Further, a historical analysis also teaches us that ideas about blood are closely related to wider social ideas about blood, for example, that blood is risk-carrying and a potential pollutant.

Chapter 3, “Literature Review” related existing anthropological and sociological literature to the themes identified in particular areas which later became the focus of the thesis, for example risk and how the changing nature of the perception of risk affected the giving relationship in contemporary British society. Titmuss’ concept of unfettered altruism was reassessed to engage with actual reasons for giving, and the relationship of the host body to the donated blood was revealed to be one which had been impacted upon by biotechnological capacities. The chapter also served to debate the current symbolic meanings of blood and blood donation in contemporary British society. Further, the chapter highlighted the changing nature of citizenship and these changes can be extrapolated to blood donation.

The Methodology chapter, Chapter 4, provided justification, validation and reflection concerning the methodological and epistemological approach of the thesis. This chapter was also where reflections on the design and structure of the project gave way to reflections on the role of the researcher and how this related to the data gathering in relation to the researcher herself. The long time span of the study proved to be vital in allowing a much more vivid portrayal of blood donation than was the case for Titmuss (1997), Tutton (2002) and Busby (2004). This was because staying with my subject over the elongated period of time between 2004 and 2008 allowed me to unearth fresh data which led to theories as to why people donate, and how the motivations to donate are mediated and controlled by background societal change.

The chapter illustrated issues related to ethnographic research and the difficulties in negotiating a space for research. It also provided valuable reflections on the freedoms and constraints in such a free field as mine was to become. The chapter introduced the

donors and the locale of the field. It also provided insight into the experience of the researcher as well as the researched, by utilising excerpts from the fieldwork. The interpretative methodology employed became a chance to reflect and debate on seminal interpretative theorists and allowed a fresh insight into how easy it is to miss potentially rich data by omitting to observe as well as to listen to the informants. It also underlined the need to immerse oneself in the field before any themes can effectively be drawn out.

These initial chapters were essential to contextualise the present location and symbolism and understanding about blood in a theoretical framework. In these next four chapters I analysed the data gathered and related it to the concepts that were the objectives of this thesis.

Chapter 5 was entitled “From Gift to Risk: Challenging the Orthodoxy of Altruism” to reflect the content of the narratives of the donors which revealed that blood, including donated blood, was changing in its symbolic meaning in society. The chapter was an opportunity to relate my data to the seminal data on donors and blood in the work of Richard Titmuss (1997), and relate the public action of blood donation to the concepts of risk management. This chapter related the fieldwork about blood donation to the risk society thesis of Beck (1992) and to the surveillance society of Foucault (1977). The chapter argued that modern donors are well aware of the dual capacity of blood to be either a gift or a risk, or indeed both, and in presenting new knowledge it asserts that contemporary donors take measures to manage their own body so as to keep the gift as risk free as possible.

As an extension of this new notion of blood as risk, theories of active citizenship were applied in Chapter 6, entitled “Deferment and Citizenship: Too Risky to Give”,



extending the risk theory analysis, and this chapter concentrated on extending the notions of moral panic (Cohen, 2002) and good citizenship associated with blood and blood donation. It argued that the new moral panics concerning blood are covert, being managed subtly by the growing bureaucratic organisation of the NHSBT, rather than in the public eye. The central point of this chapter concerned issues of those wanting to give their gift of blood being classified as deferred. Deferment issues were discussed from the donor's perspective and they were related to population-level deferment, thus illustrating the tensions beginning to build in the gift relationship of contemporary Britain. The chapter highlighted the problematisation of groups such as the older donor and the disabled donor, as well as the potentially infected donor, thus arguing that being altruistic is no longer the defining characteristic of a desired donor; the donor must present their body in a safe and healthy condition to donate and is expected to be able to prove it. This is linked to the emotional labour of giving that donors feel, either bodily during the process, or mentally if they have a special blood group, occupation or significant family need for blood, and to the onerous task of keeping healthy enough to keep on giving. The thesis introduced the concept of "ableness" in this respect and allows us to consider blood donation to be a form of "body work". These aspects were further developed in the subsequent chapter, as they extended the central tenet of the thesis that changes in the donation relationship have occurred.

Chapter 7, "Giving to Get Back: From Altruism to Covenant", introduced another original way of understanding the rationale for giving blood by extrapolating the concept of covenanted donation rather than altruistic donation. Many donors, it was argued here, only give to get back a similar safe donation should they or their family need it. This idea was linked to the role of the family as both the reason for giving and

for whom the donations were intended. This was a departure from the giving to strangers paradigm embedded in early work on blood donation. This chapter was concerned with reporting the changes in whom donors give their blood for, who they would like to benefit from it and who they would not like to benefit from their probity. The salient theoretical aspect from this chapter is the notion or theory of blood donation being a covenanted donation relationship rather than a gift relationship.

The subsequent chapter, Chapter 8 “Blood Donation, the Body and the Self”, represents the final strand in the thread of changes that this thesis asserts have occurred. It is concerned with the status quo of donated blood in relation to biomedical technology and blood’s nascent social life i.e. blood outside of the body. It served to set out the final change to blood donation, which I assert has occurred in the late modern-era gift relationship and, although theoretically distinct, it acted to connect the preceding chapters, since the changes related to both why and who donors give for as related to the background societal and biomedical events. It introduced original ideas about how blood was perceived to be related to the host body, with donors reflecting on what it was they were actually donating or giving away, in relation to the perceived self in a new donation world, a hierarchical self. Weiner’s (1992) concept of inalienation was debated in relation to blood component therapy becoming a replacement for whole donated blood therapy, thus creating a tension in the understanding by donors of exactly what their gift is manufactured into. This creation of what was termed “man-made blood” has caused tensions in the system due to the secondary market of blood component economies. The chapter introduced debate in relation to the concept of the donating self; donors were hierarchising their body parts for donation, depending on how much importance, specialness or need the part had to them. The chapter further

introduced the concepts of the liquid/solid self and the inner/outer self. Donors verbalised the nexus between the body and a new body part; blood fragments. Donors also talked of a new relationship between blood donation and research and the need for blood parts rather than whole blood to give to strangers in need.

## **9.2 Significance of the findings**

This thesis has presented evidence gathered from the data gleaned from 80 self-selected open-ended interviews and fieldwork at a blood donation centre in the south of England. These results, it has been argued, offer an original and current set of narratives of blood donation, because it is directly as a result of allowing donors to relate their own story and version of their reasons for being a blood donor that I was able to create the thesis as presented here. The ethnographical methodology was crucial to the success of the project, with donors being interviewed where the donation took place. This proximity to the physical action of giving was novel, as it spurred on the talk at the fieldwork location about why and for whom this small group of ordinary people give their blood. This thesis asserts that blood has altered in its relation to both society and the host body, and in its symbolic meaning in contemporary Britain. In particular, the thesis has challenged the conceptual difficulties in continuing to understand blood donors as archetypal altruists.

Blood donation as a public act of altruism has become altered, it has been argued, due to the threefold influence which is the foci of the thesis. Firstly, the risk society fervour has created a need to modify and control the perceived uncontrolled altruism which underpinned the relationship between society and the blood donor in the past. Secondly,

these changes have created tolerance and expectations of donors conforming to the concept of an ideal donor who is safe and has a sustainable interest in maintaining their donating activity, to ensure a safe blood supply in the future.

The most significant finding from the data has been related to the notions of citizenship, both at the inception of the blood donor service and in contrasting the contemporary ideas surrounding the active citizen. This is a significant area for further work, as it is within the concepts of citizenship that social tensions can occur. The role of the blood donor has been highlighted to embody the changed notions and roles and responsibilities concerning active citizenship in the way the donors understand the personal constraint and professional dominance required to ensure a safe donated blood pool in modern Britain. The changes that have taken place in recent years in Britain in the donor world highlight concern for good citizenship, control and management of the donor body, and the management and exclusion of risk laden sections of society are all evident in the data from the ethnography.

Thirdly, this thesis charts the rise of techno-medical advances in relation to blood component therapy and the creation of blood fragments that has led to donors reordering the relationship of their blood to their body. This aspect was related to the concept of inalienable gifts by Weiner (1992). This served to use the data to illustrate the impact on blood donation by biomedical practices and commodification and consider the notion that blood can be both alien and inalienable in the new donation world. The new man-made blood is more potent and valuable due to these biomedical advances than the gift of donated whole blood alone. Blood has become a malleable body part which can be transformed and bear little resemblance to the state in which it is donated. This may

further challenge the potentially fragile remnant of altruistic donors, as the new generation of donors may become aware of the capital value of their body part. This particular aspect is an area for future research and direction of the findings.

This concluding chapter has served to draw together the different strands of the journey blood has made since it was first successfully transfused and denoted the gift of life, and later the embodiment of the post-war good Samaritan. The impact on blood donors in the globalised world has led to reconsiderations of altruism as the salient social force that motivated donors give to strangers.

At the outset of the study these themes were absent from the literature on blood and blood donation. This thesis has argued that the latter-day donor has some similar reasons for giving, the family for instance, but that stronger influences stemming directly from the background social changes are more significant in directing and controlling donor motivation and behaviour.

The thesis adds to anthropological and sociological knowledge because it enables a more comprehensive understanding about what blood and blood donation means in contemporary British society. It informs us about how to best enable the deconstruction of this vital public activity by applying a new range of sociological theories as a framework for understanding this public action.

Finally, it points the way for understanding potential new developments in the gift relationship, that of an awareness of the value and special nature of the gift in relation to the new immunological and fragmented body and how being and especially remaining a safe blood donor is indicative of a good citizen; the donor-citizen.

This thesis has told the modern story of blood donation in Britain. As a result, this thesis adds significant novel thinking about blood and blood donation because it hints at potential tensions as the body part and fragment world enters the once safe and altruistic world of the donor and challenges the orthodoxy of altruistic blood donation.

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