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Where do human organs come from? Trends of generalized and restricted altruism in organ donations

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ABSTRACT

The supply of human organs for transplantation is undergoing a dramatic transformation. Using data from 30 countries for the years 1995–2007, this paper suggests that organ supply today is more dependent on direct donations than on the collective organ pool. This trend is analyzed by studying different modes of altruism: "generalized altruism" relates to the procurement of organs through a one-for-all collectivized system of donations whereas "restricted altruism" relates to one-to-one donations with organs considered personal gifts. The data suggest that transplants are becoming less and less social goods and more and more personal gifts. This trend is documented and discussed in light of the linkage that social scientists hypothesize between altruism and social solidarity. Whereas altruism is conceived as generating social solidarity, the rise in direct organ donations restricts the effect of altruism to one-to-one interactions rather than one-for-all giving.

Introduction

Ever since the term "altruism" was first coined by August Comte (2009 [1851]) in the second half of the 19th century, it has been perceived in the social sciences as a generator of social cohesion and solidarity. Socio-biologists, economists, psychologists and sociologists have viewed altruism and other-oriented behaviors such as voluntarism and self-sacrifice as indicators of social solidarity and mutualism (Piliavin and Charng, 1990; Wuthnow, 1991, 1995). Discovering what motivates the altruistic individual becomes the objective of both social research and policy-making. Richard Titmuss, an architect of the modern welfare state, followed sociologist Sorokin (1954) in introducing altruism and gift-giving as tools of social policy. Central to his vision was that altruism could be "created", providing people with institutional "opportunities" to demonstrate their altruistic behavior so that social solidarity and mutualism would augment and market-like social transactions and commodification processes would be reduced.

Such an altruism-based policy underlies organ donations: here limits to the market are explicitly set and standards are devised in ways that contrast sharply with straightforward marketplace transactions. Selling one's body for money is perceived as the lowest form of capitalism; although studies have shown that the line separating alienability and inalienability is much more blurred than commonly assumed (Radin, 1996; Zelizer, 2000), prostitution, slavery, and other forms of body commodification are unanimously condemned. When use of the body is unavoidable (in certain medical procedures or in medical research) donations and gifting often comprise the chief legitimate mode of supply (Healy, 2006; Simmons, 1991; Waldby and Mitchell, 2006). Regulating this type of gifting has thus become a matter of public policy, and it is in these areas we find economies that operate according to an altruistic mode of supply. Within this context, the regulation of organ donations offers a classic example of altruism-based social policy (Healy, 2004; Simmons, 1991).

Nonetheless, the politics of altruism poses a challenge to the social science of altruism, to wit: Can altruism be sufficient as a basis of organs donations? In this paper I wish to examine trends in organ donations and discuss their impact on social solidarity and individualization processes. Organs can be taken from cadavers and, in the case of kidneys, liver and lung lobes, from living persons as well. This distinction – I argue here - bears importance for understanding the different forms of altruism and social ties involved in these two forms of organ donations. It is important to note that I do not address altruistic conduct *per se*, nor whether specific forms of organ donation in fact constitute altruism. Instead of altruism as an individual conduct, I am interested here in altruism as a tool of a policy line. I wish to shift

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the focus on altruism from social psychology to an institutional analysis. Taking Healy's (2000, 2004) perspective on altruism and organ donations, I approach altruism as an institutionalized structure, a regulated form of conduct, a ready-made concept of organ procurement organizations. Instead of examining whether living donations are more altruistic or less altruistic than post-mortem donations, I am interested in the societal outcomes of these two types of donations. In other words, I wish to test the thesis promoted by Sorokin (1954) and Titmuss (1997 [1970]) that altruism can be induced to the degree that it would first foster social solidarity and second serve as a buffer against commodification processes.

Generalized altruism: human organs as social goods

The study of generalized exchange lends itself easily to the world of post-mortem organ donations. Most prominent in this context is the affinity between the "gift of life" concept of organ donation and the classical study of Marcel Mauss on gift exchanges in archaic societies. Indeed, when Mauss argued that "to give something is to give a part of yourself" (1954:10), he referred to the spiritual characteristic of the gift (the Maoric *hau*) upon which the obligation to reciprocate is grounded, but his conceptualization of gift economy as obligates reciprocation and thus enhances social ties serves as the bedrock for regulating bodily exchanges from blood, to ova and organ transplantations. Titmuss (1997 [1970]) was the first harnessed Mauss to modern social policy by arguing that the principles Mauss found as directing gift-relationship should underlie the principles of modern voluntary blood donorship.

Although the Titmussian model was criticized and updated (Arrow, 1972; Waldby and Mitchell, 2006) and gift theory was further developed (Komter, 1996; Vandevelde, 2000; Weiner, 1992), the linkage between Titmuss and Mauss established the model of indirect donations as a paradigm for an institutional redistribution of social goods outside the market. This model of indirect, materialistically unrewarded (i.e. altruistic) giving that is mediated by formal health agencies is addressed here as "generalized altruism". Written in the pre-Thatcher and the pre-HIV eras, generalized altruism was for Titmuss not only a way of providing better and safer blood transfusions, but also the building blocks of social solidarity and social cohesion through welfare organizations (Berridge, 1997; Healy, 2000; Oakley and Ashton, 1997).

In the supply of cadaveric organs for transplantations, generalized altruism underpins the ethos and practice of organ procurement organizations. As early as 1985, only a few years after transplantations became routine medicine, The Transplantation Society (TTS) illustrates the generalized altruism model in the provision of organs:

> The Council of The Transplantation Society takes the view that the donation of an organ is a gift of extraordinary magnitude and that transplant surgeons hold a donated organ in trust for society…. It must be established by the patient and the team alike that the motives of the donors are altruistic and in the best interest of the patient and not for self-serving and for profit. (WHO 1994:463)

Although The Transplantation Society only holds recommendatory power, its definition of altruism reflects a broad consensus within the official transplant community with regard to the centrality of altruism as the guiding motivation for organ donations. During the 1980s and 1990s, along with the routinization of transplant medicine, altruism was codified as the "default method" of organ supply around the world (Delmonico, 2008; WHO, 1994). In most countries, organ procurement was grounded in legislation that introduces organs as social goods which are held by the medical team "in trust for society" and are allocated objectively to patients in need.

Formal procurement methods of cadaveric donations differ in their consent policies as well as in other organizational features. Nonetheless, they all share the concept of replaceable organs as social goods, carrying three distinctive features: First, as indirect giving, organ donations are the result of a donation to society as a whole, without any specifications regarding the recipient's identity. Second, not motivated by materialistic incentives, deceased organ donations are considered manifestations of altruism and third, the organs' circulation necessitates an organized institutional setting of coordination that can source, match, transfer and transplant an organ in a relatively short time. These three characteristics yield an institutional and ethical construct that can best be described as a form of "bodily communism": a collectivized organization of organ sharing - from each according to his good will (and his physiological state), to each according to his needs with the involvement of the state as redistributive agency.

The circulation of deceased organs entails a triad structure: donor, recipient and a set of coordination agencies. It necessitates a strong institutional agency in the procurement of organs as well as in their distribution so that both donor and recipient become parts of a collectivized regime of generalized altruism. At the institutional level, generalized altruism provides individuals with opportunities to express altruistic behavior (Healy, 2004, 2006). At the social level, it sustains transplant medicine by maintaining a constant supply of organ donations as well as buffering against trends of organ trafficking. At the political level, it promotes the notion of collective organ sharing and solidarity. The anthropology of the gift converges with welfare politics in forming an economy of replaceable organs that is dissociated from the assumptions of capitalism on possessive individualism and the direct quid-pro-quo mode of market society.

Restricted altruism: human organs as personal gifts

In contrast to cadaveric organ donation, the search for a living organ donation (mostly of kidneys, but of liver and lungs lobes as well) is outside the purview of public procurement organizations. In contrast with cadaveric donations where the procurement and distributions of organs are according to public and open criteria, organ donations from living donors are the result of personal initiatives. The role of the transplant coordinator is then left to examine the medical prospects of the donation and whether it is altruistic, i.e. not stipulated by materialistic incentives (Delmonico 2004; Spital 2003). Since genetic proximity promises a good match, kin-members are primary candidates for a donation. Nevertheless, advancements in post-operative treatments enable the transplant of an organ from a genetically unrelated donor and thus the potential pool of donor expands beyond the genetic family. Although transplant coordinators hold the key for approving the match, they have no role in the actual process of organ procurement from living persons.

This is a key factor in the exchange status of the donated organ. Whereas in indirect donations, donated organs are collectivized to the status of social goods, in direct donations, the donation is specified and personal so that altruism is restricted to the limit of the parties involved. Furthermore, while the background of the deceased donor is irrelevant in considering his or her motives for signing a donor card, living organ donation is legitimized by virtue of the social proximity between donor and recipient. Organ donation policies thus emphasize familiarity in direct donations and anonymity in indirect donations. It is this distinction – familiarity