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Rethinking Body Property

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RETHINKING BODY PROPERTY

KARA W. SWANSON*

ABSTRACT

Body products, including blood, gametes, and kidneys, are a routine part of contemporary medicine. They are also controversial. There is a strong preference for donated gifts, based on an intuition that gifts are pure, altruistic, and healthy, and that purchased products (commodities) are tainted, exploitative, and dangerous. Law and policy reflect this dichotomy, preventing market exchanges either by declaring body products non-property or banning sales by the supplying body. Yet with growing scarcity leading to injustice in the allocation and harvesting of body products, calls to allow sales have been increasing, motivating proposals to increase supplies by compensating bone marrow and breast milk suppliers.

This Article contributes to these pressing debates in two ways. First, it uses original historical research to demonstrate that the morally inflected gift/commodity dichotomy is a historical artifact, neither universal nor inevitable, and thus need not be the assumed basis for law and policy. Second, in a novel use of the intellectual history of property, it brings body products for the first time into the framework of recent progressive property scholarship to rethink body property.

The first body products, disembodied breast milk and blood, entered medicine at the turn of the twentieth century. I argue that for a half century, these body products were property-in-action, bought and sold as a means to the medically defined ends of advancing recipient and supplier health. The dichotomy and condemnation of sales emerged only later, as body products transitioned to property-at-law. I argue that the focus on supplier compensation was not a needed correction to marketplace harms, as commonly assumed, but rather a result of (i) medical opposition to single-payer health care, (ii) product liability law, and (iii) racism. This transition, analyzed in light of historical trends in property theory, is revealed as a shift to a narrower understanding of body products as property, presumed to satisfy only the individual preferences of market participants.

Using this analysis, this Article offers guidance for rethinking body property. Exposing body product exceptionalism within the law of property, this Article uses history to demonstrate how body products, like other forms of property, can have purposes beyond individual preference satisfaction. In place of regulation focused on banning market-alienability, the law of body products as property can be theorized and rewritten to focus on the ends of patient treatment and public health, incorporating the use of regulated markets to serve the goals of increased access to medical treatment while also avoiding supplier exploitation.

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I. INTRODUCTION

People are not property. This statement, supported by the Thirteenth Amendment abolishing slavery, was not always accurate. That we can now take it as a basic principle of U.S. law is the result of a bloody civil war fought to determine the legality of owning humans.¹ There is no similar blanket prohibition in law against people as a *source* of property. To the contrary, the human body in the United States has always been a source of marketable property. Americans, like people since the ancient Roman Empire, have sold their hair.² Women have sold their breast milk as wet nurses, another centuries'-old form of self-commodification that persisted in the United

1. Although slavery has been outlawed in the United States, the legacy of race-based slavery continues to permeate U.S. law, politics, society, and culture, including the subject of this Article: property sourced from human bodies. See MICHELE GOODWIN, *BLACK MARKETS: THE SUPPLY AND DEMAND OF BODY PARTS* 22-23, 193-211 (2006) (arguing that the legacy of racialized slavery is used too often to prevent body product exchanges that would promote the interest of African Americans); Margaret Jane Radin & Madhavi Sunder, *Introduction: The Subject and Object of Commodification*, in *RETHINKING COMMODIFICATION: CASES AND READINGS IN LAW AND CULTURE* 8, 9 (Martha M. Ertman & Joan C. Williams eds., 2005) [hereinafter Radin & Sunder, *Introduction*] ("The Thirteenth Amendment forms the backdrop of these cases.").

2. *E.g.*, Elizabeth Bartman, *Hair and the Artifice of Roman Female Adornment*, 105 *AM. J. ARCHAEOLOGY* 1, 1-2 (2001); Mary K. Gayne, *Illicit Wigmaking in Eighteenth-Century Paris*, 38 *EIGHTEENTH-CENTURY STUD.* 119, 121-22 (2004). The prevalence of the practice in the United States is evidenced in popular literature. See, *e.g.*, LOUISA MAY ALCOTT, *LITTLE WOMEN* 315-21 (The Floating Press 2009) (1869) (Jo March sells her hair to raise money for her family.); O. HENRY, *The Gift of the Magi*, in *THE COMPLETE EDITION OF O. HENRY: THE FOUR MILLION* 15, 17-18 (1906 ed.) (Della sells her hair to buy her husband a Christmas present.).

States through the early twentieth century.³ Even after the ban on slavery, propertization of body parts continued to be seen as lawful and appropriate. Twentieth-century medical advances led to an expansion of possible body property as doctors offered people money for their blood, flesh, organs, and gametes, accompanied by a thriving trade in products harvested from cadavers.⁴

Despite this long history of buying and selling products sourced from the human body, it is intensely controversial in law and society to consider human body products as property in the twenty-first century, and particularly to buy and sell such products. In recent years, the federal government has fought a proposal to offer limited compensation to bone marrow suppliers in order to address the shortage of donors of non-northern European ancestry.⁵ Responding to advances in transplanting faces and hands, federal regulators also moved to expand the reach of the National Organ Transplant Act (NOTA), the federal law banning the sale of human organs, by redefining “organ” to include hands and faces and thus banning compensation to families making cadaveric donations of these body parts.⁶ Breastfeeding activists in Detroit, Michigan, waged a public campaign against the Mother’s Milk Cooperative which offered to buy breast milk at \$1 per ounce, arguing that “breast milk is priceless”⁷ and disparaging “[m]others pumping just for profit.”⁸

3. See generally VALERIE FILDES, *WET NURSING: A HISTORY FROM ANTIQUITY TO THE PRESENT* (1988); JANET GOLDEN, *A SOCIAL HISTORY OF WET NURSING IN AMERICA: FROM BREAST TO BOTTLE* (1996).

4. ANNIE CHENEY, *BODY BROKERS: INSIDE AMERICA’S UNDERGROUND TRADE IN HUMAN REMAINS* (2006); GOODWIN, *supra* note 1, at 111-12 (noting that the Uniform Anatomical Gift Act does not preclude payments for organs and body parts used in research); SUSAN E. LEDERER, *FLESH AND BLOOD: ORGAN TRANSPLANTATION AND BLOOD TRANSFUSION IN TWENTIETH-CENTURY AMERICA* (2008); KARA W. SWANSON, *BANKING ON THE BODY: THE MARKET IN BLOOD, MILK, AND SPERM IN MODERN AMERICA* (2014). While this Article does not address cadavers themselves as property, entire bodies too have had value in medical marketplaces in Europe and North America, sought by doctors wanting to teach and learn anatomy and surgery. See *infra* note 30 and accompanying text.

5. See *Flynn v. Holder*, 684 F.3d 852, 858 (9th Cir. 2012).

6. 42 U.S.C. § 274e(a), (c) (2012); see also Organ Procurement and Transplantation Network, 78 Fed. Reg. 40,033-42 (July 3, 2013) (amending 42 C.F.R. pt. 121) (final rule issued by the Department of Health and Human Services incorporating expanded definition of “organ”); Liz Kowalczyk, *The Future of Face and Hand Transplants*, BOS. GLOBE (Mar. 17, 2014), <https://www.bostonglobe.com/lifestyle/health-wellness/2014/03/16/organ-transplant-leaders-creating-national-system-allocate-hands-faces-disfigured-patients/h0VLdmJ7S4CGIUjHIEYEIO/story.html> [<https://perma.cc/S47F-JXHY>].

7. Mahira Ali, Comment to *An Open Letter to Medolac Laboratories from Detroit Mothers*, BLACK MOTHERS’ BREAST FEEDING ASS’N (Jan. 12, 2015), <http://blackmothersbreastfeeding.org/2015/01/open-letter-to-medolac-laboratories-from-detroit-mothers/> [<https://perma.cc/V2R8-2UD7>].

8. Darlene Henderson, Comment to *An Open Letter to Medolac Laboratories from Detroit Mothers*, *supra* note 7; see also Kim Kozlowski, *Activists: Breast Milk Corp. Targeting Black Moms*, THE DETROIT NEWS (Jan. 13, 2015), <http://www.detroitnews.com/>

Doctors, the general public, and lawmakers consider the divide between body products as gifts, transferred by their suppliers without compensation, and body products as commodities, transferred for compensation, as sharp and significant. The gift vs. commodity dichotomy is understood in terms of a moral hierarchy in which gifts are pure, altruistic, and good, and commodities are tainted, exploitative, and bad.⁹ As medical science offers new hope and healing through the use of body products, both American law and society prefer to categorize such products as “gifts” and “donations,” rather than as property or marketable goods.¹⁰

What has been nearly forgotten in these controversies is that, like the ban on humans as property, the legal and social status of human-sourced property is neither universal nor immutable, but rather a historically contingent construct. Using original historical research into the first body products routinely used in medicine, breast milk and blood, this Article demonstrates that a century ago, body products were matter-of-factly treated as property and bought and sold by suppliers, patients, and doctors in Detroit and elsewhere. Further, it reveals that the current focus on the divide between gifts and commodities did not exist in first half-century of the exciting developments that brought body products into the mainstream of medicine.¹¹ That dichotomy, now the frame for current policy debates, was itself a late twentieth-century development.

This Article argues that it is critical to understand this history and to rethink body property in order to establish an improved legal framework for obtaining and allocating body products. Our current laws assume the significance of the gift vs. commodity dichotomy and the truth of the standard narrative of good gifts and bad sales. The dichotomous approach to body products and markets is both shopworn and actively harmful, leading to injustice in both the supply and allocation of many body products.¹² At a time when the scarcity

story/news/local/wayne-county/2015/01/12/detroit-breast-feeding-activists-protest-co-op/21675583/ [https://perma.cc/ZM2J-HMRP].

9. The origins of this dichotomy and hierarchy are explained in Part V *infra*.

10. I am using property as a broader category than commodity. In my usage, property is both a legal and theoretical category and includes market-alienable property and market-inalienable property. I am using commodity to refer to property exchangeable in markets, and “marketization” in preference to “commoditization” to refer to the process of becoming exchangeable in markets. The terms “commodity,” “commodification,” and “marketization” are discussed in the work of Martha M. Ertman & Joan C. Williams, *Preface: Freedom, Equality, and the Many Futures of Commodification*, in *RETHINKING COMMODIFICATION*, *supra* note 1, at 1, 2-3 [hereinafter Ertman & Williams, *Preface*].

11. As discussed further in Part II *infra*, I use the term “body products” to refer to material sourced from the human body, a category that includes both renewable and non-renewable body products, as well as products sourced from living bodies and from cadavers.

12. The harms of body product scarcity and resulting gray and black markets have been explored by legal scholars and other social scientists, most prominently with respect

of body products is limiting the ability of Americans to access needed treatment, this Article uses history first to denaturalize the dichotomy and the standard narrative and then to rethink body property to provide a fresh basis for thinking about the law and policy of body products.¹³ In place of a focus on marketization through supplier payment, this Article offers a historically grounded understanding of body products as property to rethink the relationship between body products and markets in theory and practice.¹⁴

Today the belief that gifted body products are superior to sold products is explained in terms of protecting supplier and recipient health. Payment to suppliers is understood as the source of harm to both parties. It is argued that payment incentivizes suppliers to sell body products despite resulting damage to their own health, and/or to sell body products despite a medical history that indicates that their body product might be harmful to the recipient's health. These arguments are often accompanied by arguments that considering body products as property, and particularly as what Margaret Radin

to organs, where scarcity is increasing and life-threatening. *See, e.g.*, MARK J. CHERRY, *KIDNEY FOR SALE BY OWNER: HUMAN ORGANS, TRANSPLANTATION, AND THE MARKET* (2005); GOODWIN, *supra* note 1, at 184-90; JAMES STACEY TAYLOR, *STAKES AND KIDNEYS: WHY MARKETS IN HUMAN BODY PARTS ARE MORALLY IMPERATIVE* (2005); Radhika Rao, *Property, Privacy, and the Human Body*, 80 B.U. L. REV. 359, 435-36 n.392 (2000). For arguments that despite scarcity, organ sales are too harmful to be allowed, see, for example, Alexander M. Capron, *Six Decades of Organ Donation and the Challenges that Shifting the United States to a Market System Would Create Around the World*, 77 LAW & CONTEMP. PROBS. 25, 51-58 (2014); Leon R. Kass, *Organs for Sale? Propriety, Property, and the Price of Progress*, 107 PUB. INT. 65, 70-71 (1992).

13. This project thus joins work in sociology that has demonstrated the absence of a divide in lived experience between market and non-market, another way of denaturalizing the gift versus commodity dichotomy. VIVIANA A. ZELIZER, *PRICING THE PRICELESS CHILD: THE CHANGING SOCIAL VALUE OF CHILDREN* (1985); VIVIANA A. ZELIZER, *THE PURCHASE OF INTIMACY* (2005) [hereinafter ZELIZER, *PURCHASE OF INTIMACY*]; VIVIANA A. ZELIZER, *THE SOCIAL MEANING OF MONEY: PIN MONEY, PAYCHECKS, POOR RELIEF, AND OTHER CURRENCIES* (1994). For an explanation of Zelizer's work and its influence on scholarship outside of sociology, see Martha M. Ertman, *For Both Love and Money: Viviana Zelizer's The Purchase of Intimacy*, 34 LAW & SOC. INQUIRY 1017 (2009) [hereinafter Ertman, *For Both Love and Money*]. Zelizer's insights have been applied to late twentieth-century and early twenty-first-century body product exchange in RENE ALMELING, *SEX CELLS: THE MEDICAL MARKET FOR EGGS AND SPERM* 126-33 (2011); KIERAN HEALY, *LAST BEST GIFTS: ALTRUISM AND THE MARKET FOR HUMAN BLOOD AND ORGANS* 11-12, 14, 25-27 (2006).

14. As discussed in Part III *infra*, the need to address questions of property related to body products has been long acknowledged by the courts and scholars. *See, e.g.*, Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 487-97 (Cal. 1990); E. RICHARD GOLD, *BODY PARTS: PROPERTY RIGHTS AND THE OWNERSHIP OF HUMAN BIOLOGICAL MATERIALS* (1996); MARGARET JANE RADIN, *CONTESTED COMMODITIES: THE TROUBLE WITH TRADE IN SEX, CHILDREN, BODY PARTS, AND OTHER THINGS* 125-26 (1996) [hereinafter RADIN, *CONTESTED COMMODITIES*]; Julia D. Mahoney, *The Market for Human Tissue*, 86 VA. L. REV. 163, 201 (2000); Stephen R. Munzer, *Kant and Property Rights in Body Parts*, 6 CANADIAN J.L. & JURIS. 319, 319-20 (1993); Margaret Jane Radin, *Property and Personhood*, 34 STAN. L. REV. 957, 966 (1982) [hereinafter Radin, *Property and Personhood*]; Meredith M. Render, *The Law of the Body*, 62 EMORY L.J. 549, 552-54 (2013).

calls “market-alienable” property, is inherently damaging to the dignity and value of all humans.¹⁵

History teaches that while earlier actors were also focused on supplier and recipient health, they understood the relationship between payment to suppliers and such harms very differently. Using a law and society approach, I examine milk and blood as body products in the first decades of their use as property-in-action, following doctors managing body product exchanges in order to treat patients before such products were considered potential property-at-law. I argue that the historical evidence shows two assumptions underlying early body product sales: (1) body products should be treated as property and (2) the purposes of propertization appropriately included (a) the maintenance of a safe and adequate supply of body products to treat patients, (b) a means of allocating that supply based on medical need rather than the ability to pay market rates, and, often, (c) promoting public health goals through forms of compensation offered to suppliers and their families. Operating on these assumptions, rather than on the assumption that sales were inherently different from and inferior to gifts, doctors bought and sold human milk and blood for a half-century. Only at the mid-twentieth century did the focus on banning supplier compensation emerge. I use history to demonstrate that the negative perception of supplier compensation arose out of the opposition of the medical profession to government-funded health care, developments in product liability law, and the racism of white Americans.

Having denaturalized the dichotomy by demonstrating that the perceived link between supplier payment and medical harms is far from inevitable or immutable, this Article also reconsiders the forgotten past of body products as exchangeable property to argue that the crucial question that should guide the market alienability of body products is the nature of body products as property. Previous scholars have identified a dialectic in American property law between two understandings of property: commodity versus propriety.¹⁶ Property

15. RADIN, CONTESTED COMMODITIES, *supra* note 14, at 16-29; Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1849-51 (1987) [hereinafter Radin, *Market-Inalienability*]. For a more detailed articulation of the harms of commodification, including harms of corruption and damage to personhood, see generally, for example, RADIN, CONTESTED COMMODITIES, *supra* note 14; MICHAEL J. SANDEL, WHAT MONEY CAN'T BUY: THE MORAL LIMITS OF MARKETS (2012); RICHARD M. TITMUS, THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY (Ann Oakley & John Ashton eds., 1997) (1970). Note that this broad-brush description of the standard narrative and perceived dangers of commodification glosses over considerable nuance in the scholarship regarding property, personhood, and markets. In addition to the sources cited here, see RETHINKING COMMODIFICATION, *supra* note 1 (an edited collection of scholarship exploring these issues); Ertman, *For Both Love and Money*, *supra* note 13 (reviewing influence of sociology of markets on family law and extending analysis to transfers of genetic material).

16. GREGORY S. ALEXANDER, COMMODITY AND PROPRIETY: COMPETING VISIONS OF PROPERTY IN AMERICAN LEGAL THOUGHT, 1776-1970 (1997) [hereinafter ALEXANDER,

as commodity (sometimes described as market property or liberal property) understands property to be that which is traded in markets. Property as propriety (sometimes described as republican property or civic property) understands property by the purposes for which it is created and exchanged, whether traded in markets or not.

Using the intellectual history of property theory, this Article argues that body products originated as a form of civic property and that the gift/commodity dichotomy arose when the understanding of body products as property narrowed to the market property view. It thus joins progressive property scholars in arguing that the market property view is damagingly constricting.¹⁷ The early history of body products as civic property-in-action provides a case study for thinking more expansively about property. More specifically, this history provides a basis for rethinking body property once the gift/commodity dichotomy has been decentered. In place of a regulatory approach focused on market alienability, we can consider the ends of body products as property, using the historical purposes of body product exchanges as a starting point. While leaving a full theory of body property for later work, I suggest lessons from history to guide further theorization and regulation based on a vision of body property that is created and exchanged to ensure efficient access to safe body products by all who need them for medical care and to promote a society in which overall health and well-being is enhanced.

I begin in Part II by describing the urgent need to rethink the law and policy of body products, detailing the current law and the injustices in body product allocation and exchange that have arisen out of reliance on the gift/commodity dichotomy and standard narrative. In Part III, I demonstrate how scholarship, like current law, has been constrained by the gift/commodity dichotomy. In a novel integration of the intellectual history of property theory and commodification scholarship, I identify the source of this constraint in a historically contingent understanding of body property as market property, a narrow view of property that reinforces the dichotomy and hinders efforts to move beyond it. In Parts IV and V, I analyze the history of body products. In Part IV, I explore body property in the absence of the dichotomy during the first half the twentieth century, analyzing body products as a form of medically created civic property-in-action.

COMMODITY AND PROPRIETY]; Gregory S. Alexander, Essay, *Property's Ends: The Publicness of Private Law Values*, 99 IOWA L. REV. 1257, 1260 (2014) [hereinafter Alexander, *Property's Ends*]. Other formulations of this dialectic emphasize Blackstonian property versus a social-obligation norm of property. M.C. Mirow, *The Social-Obligation Norm of Property: Duguit, Hayem, and Others*, 22 FLA. J. INT'L L. 191, 193-94 (2010).

17. See Gregory S. Alexander, Eduardo M. Peñalver, Joseph William Singer & Laura S. Underkuffler, *A Statement of Progressive Property*, 94 CORNELL L. REV. 743 (2009). For an overview of progressive property scholarship, see Ezra Rosser, Essay, *The Ambition and Transformative Potential of Progressive Property*, 101 CALIF. L. REV. 107, 109-110 (2013).

Part V examines the transition to the gift/commodity dichotomy in the mid- to late twentieth century, as body products became contested property-at-law. In Part VI, I use this reclaimed past to suggest how historical facts on the ground and early medical visions can be used as a basis for rethinking body property in law, by shifting regulatory focus from the means of body product creation (sale or gift) to the ends of body products (patient treatment and public health).

II. CONTEMPORARY BODY PRODUCTS IN LAW AND POLICY

To understand how the gift/commodity dichotomy—regarded as a moral hierarchy in which gifts are superior to sales—is harmfully limiting the law and policy of body products, it is necessary to understand the contemporary supply and use of body products and the legal regimes that govern their exchange. This Part first traces the origins and contours of body product law and then summarizes recent scholarship detailing the profound injustices in the present system of creating and allocating many body products that exist despite laws banning markets in certain body products.

A. *Body Products and Law*

In the twenty-first century, body products include renewable products such as blood, milk, semen, bone marrow, and even feces,¹⁸ as well as nonrenewable products, like kidneys, oocytes (eggs), and skin.¹⁹ All these products, like hair, can be harvested from living bodies. Other body products are harvested from cadavers, like some kidneys, hearts, lungs, and faces. All body products, however, share the feature that they have, in classic Marxist terminology, a use value and an exchange value once separated from the source body (the supplier).²⁰ The exchange value can be actualized in a transfer for compensation by the supplier and/or in transfers by one or more middlemen that manage a supply chain between supplier and recipient.

18. Fecal transplants are being used to treat certain intestinal infections. OpenBiome, in Massachusetts, is the first human stool bank. OPENBIOME, <http://www.openbiome.org/home/> [<https://perma.cc/Q9EF-2RVA>]; Peter Andrey Smith, *A New Kind of Transplant Bank*, N.Y. TIMES (Feb. 17, 2014), http://www.nytimes.com/2014/02/18/health/a-new-kind-of-transplant-bank.html?_r=0 [<https://perma.cc/2RKQ-YGSC>].

19. For discussion of skin as a body product since the early twentieth century, see LEDERER, *supra* note 4, at 6-20, and in the twenty-first century, see Render, *supra* note 14, at 550-51.

20. Ertman & Williams, *Preface*, *supra* note 10, at 2. Although I borrow from Marx's definition of "commodity," I am using the term "body product" instead because "commodity" has come to have a particular meaning in discussions surrounding what Kimberly Krawiec calls "taboo trades," which are associated with supplier compensation. Kimberly D. Krawiec, *A Woman's Worth*, 88 N.C. L. REV. 1739, 1740 n.5, 1748 (2010); Kimberly D. Krawiec, *Foreword: Show Me the Money: Making Markets in Forbidden Exchange*, 72 LAW & CONTEMP. PROBS. i, i-xiv (2009). To the extent possible, I use the term "supplier" rather than the more common term "donor" to avoid the connotation of unpaid gifting.

This disembodied, valued material is what I am calling a body product.²¹ This Article, like most of the contemporary debates about body products, concentrates on body products with use value as medical therapeutics for another person (the recipient).²² Such disembodied, medically valued material can also result as a by-product of procedures performed for the benefit of the supplying body, such as biopsies and surgeries. While the use of what is sometimes called medical “waste” raises distinct and significant legal issues about ownership and allocation of perceived value,²³ I am concentrating on body products created in ways that have long been understood by the medical profession as more problematic—taking material from a healthy body for the purpose of aiding another patient, which is a challenge to a foundational principle of medical ethics: to first do no harm.²⁴

The production and use of body products in medicine is largely a twentieth-century innovation, a result of the biomedical turn in understanding the human body. We take it for granted in the twenty-first century that doctors and scientists look to the human body as a source of therapeutics. In order to think of the human body as a source of fungible products, however, doctors, scientists, and the lay public needed to make a radical shift in their conception of the human body and in medical theory. In earlier centuries, the use of body

21. By focusing on disembodied material, I am excluding intellectual property, primarily patents, from my definition of body products. Patents can be obtained based on research using body products, and that patentability is the source of value of some body products. See, e.g., *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 481-82 (Cal. 1990) (spleen cells, as well as blood samples, used to create patented cell line); LORI ANDREWS & DOROTHY NELKINS, *BODY BAZAAR: THE MARKET FOR HUMAN TISSUE IN THE BIOTECHNOLOGY AGE* (2001); GOLD, *supra* note 14, at 138-41. I do not mean, however, by my focus on the material to imply that the law and history of human-derived intellectual property rights is divorced from the law and history of body products. My argument to the contrary is explained in Kara W. Swanson, *The Body as Slippery Object, 1900-2015* (July 2015) (unpublished manuscript) (on file with author) (presented at the International Society for the History and Theory of Intellectual Property, University of Pennsylvania); see also Stephen R. Munzer, *The Special Case of Property Rights in Umbilical Cord Blood for Transplantation*, 51 *RUTGERS L. REV.* 493, 540-44 (1999) [hereinafter Munzer, *Special Case*] (linking patents derived from cord blood with analysis of blood itself as property).

22. The uses of body products are not limited to medical therapeutics. They have uses in medical training (practicing surgical techniques), research, and safety testing (crash testing). The Article focuses on uses in direct patient treatment, although the framework outlined herein can be extended to consider other uses. A more detailed discussion of the use of body products is provided in ROHAN HARDCASTLE, *LAW AND THE HUMAN BODY: PROPERTY RIGHTS, OWNERSHIP AND CONTROL* 3-12, 78-96 (2007).

23. See, e.g., *Moore*, 793 P.2d at 491-92; Hannah Landecker, *Immortality, In Vitro: A History of the HeLa Cell Line*, in *BIOTECHNOLOGY AND CULTURE: BODIES, ANXIETIES, ETHICS* 53 (Paul E. Brodwin ed., 2000); REBECCA SKLOOT, *THE IMMORTAL LIFE OF HENRIETTA LACKS* (2010); CATHERINE WALDBY & ROBERT MITCHELL, *TISSUE ECONOMIES: BLOOD, ORGANS, AND CELL LINES IN LATE CAPITALISM* (2006); Hannah Landecker, *Between Beneficence and Chatel: The Human Biological in Law and Science*, 12 *SCI. IN CONTEXT* 203 (1999).

24. Cedric M. Smith, *Origin and Uses of Primum Non Nocere—Above All, Do No Harm!*, 45 *J. CLINICAL PHARMACOLOGY* 371, 371 (2005).

products in medicine was not only technically difficult, if not impossible, but also philosophically suspect.²⁵ Before the biomedical turn, the appropriate treatment in each case depended on the patient as much as the disease. Each body was considered an integrated whole, highly individual in its reaction to the environment. Medical care was designed to promote the restoration of the unique internal balance of each patient. Scientific medicine, informed by laboratory investigations, supported a new universal conception of the body, reducible to chemicals. The doctor's role became to identify and treat disease, which was considered curable in similar ways for all patients.²⁶ Only with this universal understanding of the human body was it possible to imagine using parts of one person to treat another.

Since this conceptual shift, the category of body products has steadily expanded. Blood, as one of the first body products, greatly enhanced surgical success through its use in transfusions. Banked blood enabled doctors to attempt daring new transplant operations, promoting the creation and use of more types of body products. The passage of the National Organ Transplant Act (NOTA) in 1984 reflected the growing success of organ transplants.²⁷ Doctors performed the first successful human kidney transplant in 1954 and then continued to attempt the replacement of more organs, including hearts, lungs, and livers.²⁸

At the time of its passage, NOTA was the first federal law regulating the compensation offered to body product suppliers. In part, NOTA and the Uniform Anatomical Gift Act (an earlier model law regarding organ donation) were designed to replace existing common law doctrines that raised doubt about the status of body products as property-at-law.²⁹ These common-law doctrines predated the turn to biomedicine. The legal status of a human corpse has long been a vexed issue in Anglo-American law. The biomedical turn depended on the knowledge and technical skills gained through decades of human dissection, a practice that created a demand for corpses in both England and the United States, leading to unsavory grave-robbing.³⁰ In

25. HOLLY TUCKER, *BLOOD WORK: A TALE OF MEDICINE AND MURDER IN THE SCIENTIFIC REVOLUTION* 31-33, 124-26 (2011).

26. For this shift, see JOHN HARLEY WARNER, *THE THERAPEUTIC PERSPECTIVE: MEDICAL PRACTICE, KNOWLEDGE, AND IDENTITY IN AMERICA, 1820-1885* (1986).

27. Jed Adam Gross, Note, *E Pluribus UNOS: The National Organ Transplant Act and Its Postoperative Complications*, 8 *YALE J. HEALTH POL'Y L. & ETHICS* 145, 166-76 (2008).

28. See J. Englebert Dunphy, *The Story of Organ Transplantation*, 21 *HASTINGS L.J.* 67, 67-72 (1969) (history and state of transplantation as of 1969); Gross, *supra* note 27, at 164, 166, 170 (further developments during 1970s).

29. REVISED UNIF. ANATOMICAL GIFT ACT (UNIF. LAW COMM'N 2006) (first promulgated in 1968); Gross, *supra* note 27, at 156-57.

30. RUTH RICHARDSON, *DEATH, DISSECTION AND THE DESTITUTE* (1987) (human dissection in England); MICHAEL SAPPOL, *A TRAFFIC OF DEAD BODIES: ANATOMY AND*

cases involving stealing corpses, mistreating corpses, and fights about autopsies and who got to control where a body was buried, courts considered whether there could be property interests in the body, at least after death.³¹

Such disputes had been governed at British common law by a rule against finding any property interest in dead bodies. This rule, like so much else in British common law, evolved after its migration to the new United States.³² American courts have been more receptive to property claims, or at least “quasi-property” claims, in dead bodies.³³ The case law of body property, however, remains scattered and inconsistent. Several state supreme courts recognize quasi-property interests in body products while other courts reject the existence of any property interest in human bodies, living or dead, or materials taken from them.³⁴ The clearest law regarding property in living bod-

EMBODIED SOCIAL IDENTITY IN NINETEENTH-CENTURY AMERICA (2002); Alan C. Braddock, “Jeff College Boys”: *Thomas Eakins, Dr. Forbes, and Anatomical Fraternity in Postbellum Philadelphia*, 57 AM. Q. 355, 361-62 (2005); Robert J. Swan, *Prelude and Aftermath of the Doctors’ Riot of 1788: A Religious Interpretation of White and Black Reaction to Grave Robbing*, 81 N.Y. HIST. 417, 424-25 (2000). There was also a link between dissection and criminal law as hanged criminals were used for anatomical study. See Richard Ward, *The Criminal Corpse, Anatomists, and the Criminal Law: Parliamentary Attempts to Extend the Dissection of Offenders in Late Eighteenth-Century England*, 54 J. BRIT. STUD. 63, 64-65 (2015); Steven Robert Wilf, *Anatomy and Punishment in Late Eighteenth-Century New York*, 22 J. SOC. HIST. 507, 507 (1989).

31. See, e.g., GEORGE H. WEINMANN, NAT’L RESEARCH COUNCIL, BULLETIN OF THE NATIONAL RESEARCH COUNCIL NO. 73: A SURVEY OF THE LAW CONCERNING DEAD HUMAN BODIES 21-23 (1929); Walter F. Kuzenski, *Property in Dead Bodies*, 9 MARQ. L. REV. 17, 17-19 (1924); Allan D. Vestal et al., *Medico-Legal Aspects of Tissue Homotransplantation*, 18 U. DET. L.J. 171, 173-181 (1955); see also Oliver Wendell Hall, Jr., Case Note, *Property Interest in a Dead Body*, 2 ARK. L. REV. 124 (1947) (noting confusion in case decided by Supreme Court of Arkansas, in which court found property rights in mutilated body but did not specify whether the property rights stemmed from common law or statute).

32. See, e.g., *Newman v. Sathyavaglswaran*, 287 F.3d 786, 791-92 (9th Cir. 2002); *Brotherton v. Cleveland*, 923 F.2d 477, 481 (6th Cir. 1991).

33. *Newman*, 287 F.3d at 792-93, 796-98 (citing cases in agreement from Indiana, Rhode Island, and California and finding that California statute created property interests for next of kin in decedent’s body); *Brotherton*, 923 F.2d at 480, 482 (citing cases in agreement from Utah, Louisiana, and Arkansas, but avoiding determination under Ohio law); *Lawyer v. Kernodle*, 721 F.2d 632, 635 (8th Cir. 1983) (identifying quasi-property rights in corpse); HARDCASTLE, *supra* note 22, at 25-28, 40-46 (discussing British “no property” principle and contrary U.S. case law). *But see* *Everman v. Davis*, 561 N.E.2d 547, 550 (Ohio Ct. App. 1989) (right to dispose of decedent’s body does not supersede coroner’s authority to temporarily hold body); *Carney v. Knollwood Cemetery Ass’n*, 514 N.E.2d 430, 434-35 (Ohio Ct. App. 1986) (describing quasi-property approach as discredited).

34. See, e.g., *Hecht v. Superior Court of Cal.*, 20 Cal. Rptr. 2d 275, 283 (Cal. Ct. App. 1993) (finding decedent had limited property interest in sperm); *Davis v. Davis*, 842 S.W.2d 588, 597 (Tenn. 1992) (quasi-property interest in frozen embryos). *But see* *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 496-97 (Cal. 1990) (no property interest in excised spleen); cases cited *supra* note 33; see also Rao, *supra* note 12, at 383-87, 414-17 (compiling cases); Render, *supra* note 14, at 556 (describing legal decisions as “awkward, unwieldy, [and] incoherent”).

ies in the new republic had been the law of slavery.³⁵ While that body of law was swept away by the Thirteenth Amendment, its legacy haunts any judicial decision regarding property in or from bodies.³⁶

Despite the recurrence of body property claims in the courts, the existing statutes regarding body products have largely sidestepped such questions. Over a century after the introduction of these new therapeutics, the law of body products remains remarkably sparse and frustratingly inconsistent.³⁷

Organs are the most comprehensively regulated body product, with NOTA providing a statutory scheme for their collection and allocation that assumes and reinforces the gift/commodity dichotomy. Congress moved quickly to outlaw compensation to organ donors after one nascent business designed to broker kidneys from living suppliers caught the public's attention.³⁸ NOTA prohibits providing "valuable consideration" for the transfer of an organ for transplant.³⁹

Blood as a body product has been regulated since 1930 when New York City passed a municipal ordinance regulating blood sales that was designed to protect the health of sellers and recipients. The city law required all blood sellers to be registered, to have regular medi-

35. ALEXANDER, COMMODITY AND PROPRIETY, *supra* note 16, at 211-40. The law of slavery is also related to the biomedical turn in that slaves were sometimes used for medical experimentation, perhaps most notoriously by Dr. J. Marion Sims, the so-called "father of gynecology." DEBORAH KUHN MCGREGOR, SEXUAL SURGERY AND THE ORIGINS OF GYNECOLOGY: J. MARION SIMS, HIS HOSPITAL, AND HIS PATIENTS 1, 42-52 (1989); Barron H. Lerner, *Scholars Argue over Legacy of Surgeon Who Was Lionized, Then Vilified*, N.Y. TIMES (Oct. 28, 2003), http://www.nytimes.com/2003/10/28/health/scholars-argue-over-legacy-of-surgeon-who-was-lionized-then-vilified.html?_r=0 [<https://perma.cc/W6B5-KDDT>]. There is also a conceptual link between property in living bodies and laws criminalizing prostitution; bans on the sale of sexual services have also been called bans on self-propertization, and human trafficking for sexual purposes is also viewed as a form of slavery. For an introduction to the debates and international literature, see generally Catharine A. MacKinnon, *Trafficking, Prostitution, and Inequality*, 46 HARV. CIV. RTS.-CIV. LIBERTIES L. REV. 271 (2011). For analysis of prostitution and commodification, see RADIN, CONTESTED COMMODITIES, *supra* note 14, at 131-36.

36. See sources cited *supra* note 1.

37. See HARDCASTLE, *supra* note 22, at 1; Render, *supra* note 14, at 554-56. Note that the Internal Revenue Service and tax courts have also had to consider the status of body products. For the inconsistent tax rulings on the issue, see Bridget J. Crawford, *Our Bodies, Our (Tax) Selves*, 31 VA. TAX REV. 695, 717-31 (2012); Lisa Milot, *What Are We—Laborers, Factories, or Spare Parts? The Tax Treatment of Transfers of Human Body Materials*, 67 WASH. & LEE L. REV. 1053, 1072-79 (2010) (detailing both IRS actions and court decisions related to taxation); see also *Perez v. Comm'r*, 144 T.C. 51 (T.C. 2015) (determining that income received by egg donor was taxable).

38. Gross, *supra* note 27, at 178-80. NOTA also established the non-profit organ procurement and transplantation network to manage the supply and allocation of organs for transplant. 42 U.S.C. § 274 (2012).

39. § 274e(a). Reimbursement of expenses resulting from transfer, such as loss of work due to hospitalization for a living kidney donation and the costs of medical care for the supplier, are not considered "valuable consideration." § 274e(c)(2). The ban only applies to transfers of organs "for use in human transplantation," not to transfers for other purposes. § 274e(a).

cal examinations, and to limit the frequency of bleedings. Suppliers were issued booklets in which dates of each sale and medical examination were to be recorded.⁴⁰ The first state laws regarding blood, however, were not aimed at regulating suppliers or at the safety of the supply. In the 1960s and early 1970s, many states passed so-called blood shield laws protecting blood banks, doctors, and hospitals against strict product liability claims for transfusion-related injuries to patients. These laws declared disembodied blood used for transfusion to be part of medical “services” and legally outside the category of a “good.”⁴¹ The effect of these laws was to deny disembodied blood the status of property-at-law, even when bought and sold.⁴²

Blood and blood products (therapeutics made from whole blood) are also regulated federally. These regulations, which are promulgated under the authority of the Food and Drug Administration (FDA) to regulate biologics, focus on safety by regulating the conditions of collection, storage, and transport.⁴³ The FDA also asserts such regulatory power over gametes, bone, and other tissues such as corneas, skin, and tendons, but has not promulgated regulations as extensively for these products.⁴⁴

Beyond these federal laws and regulations and the state blood shield laws, body products remain largely outside of any statutory framework. Some states have expanded their blood shield laws in

40. N.Y. SANITARY CODE § 108 (adopted Nov. 21, 1930, and amended Mar. 14, 1939), reprinted in FRITZ SCHIFF & WILLIAM C. BOYD, BLOOD GROUPING TECHNIC: A MANUAL FOR CLINICIANS, SEROLOGISTS, ANTHROPOLOGISTS, AND STUDENTS OF LEGAL AND MILITARY MEDICINE 115-16 (1942); see also Public Health Law of 1909 §24-a, as amended by L. 1930, c. 326, and repealed by N.Y. CONSOL. LAWS SERV. PUB. HEALTH § 5002 (LexisNexis 1953).

41. California passed the first such law in 1955. CAL. HEALTH AND SAFETY CODE § 1606 (West 1963) (original version at CAL. HEALTH AND SAFETY CODE § 1623 (West 1955)). For later laws, see Marc A. Franklin, *Tort Liability for Hepatitis: An Analysis and a Proposal*, 24 STAN. L. REV. 439, 474-75 n.203 (1972); Reuben A. Kessel, *Transfused Blood, Serum Hepatitis, and the Coase Theorem*, 17 J.L. & ECON. 265, 277 n.51 (1974); Recent Cases, *Torts—Strict Liability—Strict Liability in Tort Held Applicable in Suit by Patient Against Hospital for Injuries Received from Transfusion of Defective Blood*, 24 VAND. L. REV. 645, 649-50 n.26 (1971).

42. See *infra* Part V.

43. The FDA has been authorized to regulate blood and blood products as biologics since the 1940s. 42 U.S.C. § 262(j) (2012). See discussion of statutory changes over time in Edward L. Korwek, *What Are Biologics? A Comparative Legislative, Regulatory and Scientific Analysis*, 62 FOOD & DRUG L.J. 257, 270-72 (2007) (blood serum included in version first passed in 1902; whole blood and blood plasma arguably included by amendment in 1947; blood specifically added by amendment in 1970). For recent rules, see *Blood Notices, Proposed and Final Rules*, FOOD & DRUG ADMIN., <http://www.fda.gov/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/ActsRulesRegulations/BloodProposedFinalRules/default.htm> [<https://perma.cc/YMK9-BJ6C>] (last updated July 26, 2016).

44. *FDA Regulation of Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/P's) Product List*, FOOD & DRUG ADMIN. <http://www.fda.gov/BiologicsBloodVaccines/TissueTissueProducts/RegulationofTissues/ucm150485.htm> [<https://perma.cc/AL3X-4EKT>] (last updated May 12, 2009); see also William C. Hudson, Note, *Sperm Banking as a Strategy to Reduce Harms Associated with Advancing Paternal Age*, 70 FOOD & DRUG L.J. 573, 579 (2015).

recent decades to cover semen.⁴⁵ There are also laws in a few states regulating the collection and/or exchange of human eggs and breast milk as body products.⁴⁶ All body products, other than organs for transplant as defined by NOTA, may be bought and sold, allowing the current practices of sperm banks, egg brokers, and the Mother's Milk Cooperative.⁴⁷

B. Injustices in Body Product Creation, Allocation, and Use

The result of this patchwork is an unresolved debate in the courts about the property status of body products, coupled with statutes that assume the significance of the gift/commodity divide based on supplier compensation without always banning such compensation. Given that some body products are legally market-inalienable (e.g., organs), while others are usually gifted as a normative matter (e.g., blood), and still others are routinely bought from suppliers (e.g., gametes), the recurring debate in American law and policy is about the allocation of body products among these categories. The central question has been whether any body products should be exchangeable in markets or whether more body products should be regulated in a NOTA-like way, with compensated transfer (sales) outlawed. The discussion continues because there is increasing evidence that the current system of organ procurement and allocation is unjust, leading to proposals to lift the ban on sales. At the same time, however, the possibility of markets in human organs and the realities of organ sales raise powerful moral repugnance in many, as well as fears of

45. Jennifer M. Vagle, Comment, *Putting the "Product" in Reproduction: The Viability of a Products Liability Action for Genetically Defective Sperm*, 38 PEPP. L. REV. 1175, 1219-21 (2011).

46. Linda C. Fentiman, *Marketing Mothers' Milk: The Commodification of Breastfeeding and the New Markets for Breast Milk and Infant Formula*, 10 NEV. L.J. 29, 33-34 (2009) (noting the lack of federal regulation and that a few states have asserted the authority to regulate breast milk transfer); Kitty L. Cone, Note, *Family Law—Egg Donation and Stem Cell Research—Eggs for Sale: The Scrambled State of Legislation in the Human Egg Market*, 35 U. ARK. LITTLE ROCK L. REV. 189, 217-26 (2012) (50 state survey of egg donation laws).

47. Egg donors recently settled a class action lawsuit against the American Society for Reproductive Medicine and the Society for Assisted Reproductive Technology, in which they alleged that a cap on supplier compensation was an unlawful anti-trust violation. *Kamakahi v. Am. Soc'y for Reprod. Med.*, 2012 WL 892163, No. C11-01781 SBA (N.D. Cal. Mar. 14, 2012) (settlement reported by Jason Schlossler, *Judge Approves Settlement in Egg Donor Price-Fixing Suit*: *Kamakahi v. American Society for Reproductive Medicine*, 24 NO. 6 WESTLAW J. ANTITRUST 2 (2016)). The Cooperative's business model of supplier compensation violated the norm established in milk banking for the last forty years. Janet Golden, *From Commodity to Gift: Gender, Class, and the Meaning of Breast Milk in the Twentieth Century*, 59 THE HISTORIAN 75 (1996); see also NCBA CLUSA, *Member News: Co-op Redefines Milk Banking, First to Offer Donor Payment and Commercially Sterile Milk* (Jan. 1, 2014), <http://www.ncba.coop/press-releases/355-member-news-co-op-redefines-milk-banking-first-to-offer-donor-payment-and-commercially-sterile-milk> [<https://perma.cc/J9NK-SXGE>]. Since 2013, one of the milk banks affiliated with the for-profit business, Prolacta Bioscience, has also begun offering payment to its suppliers. TINY TREASURES MILK BANK, <http://tinytreasuresmilkbank.com/> [<https://perma.cc/DHQ9-T2EQ>].

injustice. Drawing from the evidence about organ exchange and experience with other body products, scholars have identified three broad, interlocking harms arising from body product regulation focused on supplier compensation: (a) scarcity of body products; (b) discrimination based on race and sex in terms of suppliers, recipients, and compensation; and (c) gray and black markets in which suppliers and recipients alike are vulnerable to the medical harms NOTA's ban on supplier compensation was designed to prevent.⁴⁸

Since 1984, the number of patients waiting for organ transplants has risen faster than the number of organs available for transplant.⁴⁹ This scarcity necessarily means that some patients die who might have survived had they received a transplant in time. While there are multiple contributing factors to this scarcity, many scholars have argued that the inability to offer compensation for organs to benefit the deceased's heirs or living donors directly is one factor.⁵⁰

This scarcity forces difficult decisions in allocation, leading to discrimination. Data on organ transplants show that on average, racial minorities are more likely to have their organs harvested and are less likely to receive organs.⁵¹ For patients needing a bone marrow transplant, racial minorities and those of mixed racial heritage are much less likely to find an immunocompatible match on the national donor registry. This disparity drove the plaintiffs in *Flynn v. Holder* to seek permission to offer supplier compensation, despite NOTA's prohibition. They hoped to promote their offer of compensation within minority communities, motivating more donors and reducing the current racial disparity in access to bone marrow transplants.⁵²

The current regime also supports sex discrimination in supplier compensation in ways that disadvantage women. Semen, sourced solely from men, can legally be sold, and sperm banks currently pay suppliers.⁵³ Body products sourced solely from women, breast milk and eggs, are treated differently. While they are legally saleable, they

48. See GOODWIN, *supra* note 1, at 14 (categorizing the harms as “shortage” and “bias”). This literature is vast. See sources cited *supra* note 12; see also, e.g., Symposium, *Organs and Inducements*, 77 LAW & CONTEMP. PROBS. 1 (2014); Symposium, *The Human Body as Property? Possession, Control and Commodification*, 40 J. MED. ETHICS 1 (2014); Eugene Volokh, Essay, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1837-42 (2007).

49. GOODWIN, *supra* note 1, at 7, 37-47; Philip J. Cook & Kimberly D. Krawiec, *A Primer on Kidney Transplantation: Anatomy of the Shortage*, 77 LAW & CONTEMP. PROBS. 1, 11 (2014).

50. Since organ sales are outlawed, there is no data directly supporting this claim. But cf. Nicola Lacetera et al., *Rewarding Altruism? A Natural Field Experiment 2* (Nat'l Bureau of Econ. Research, Working Paper No. 17636, 2011) (payment for blood increases willing suppliers), <http://www.nber.org/papers/w17636> [<https://perma.cc/M78M-F5CL>].

51. GOODWIN, *supra* note 1, at 5.

52. *Flynn v. Holder*, 684 F.3d 852, 858 (9th Cir. 2012).

53. Kimberly D. Krawiec, *Sunny Samaritans and Egomaniacs: Price-Fixing in the Gamete Market*, 72 LAW & CONTEMP. PROBS. 59, 61 (2009) [hereinafter Krawiec, *Sunny Samaritans*].

are largely kept on the gift side of the gift/commodity divide in practice. Non-profit milk banks refuse to offer payment, telling women their excess milk should be a maternal gift to needy babies.⁵⁴ While egg suppliers are compensated, the construction of egg sales as gift exchanges, in which generous women are compensated for inconvenience and risk—but not for their eggs—is used to limit women's compensation; for example, the American Society for Reproductive Medicine long had a policy requiring members to cap payments to egg suppliers but not to sperm suppliers.⁵⁵

Finally, the legal requirement that organs be solely gifted, creating scarcity, has not only exacerbated racial injustices in the domestic allocation of organs, but has also stimulated the development of black and grey markets as desperate patients travel to other countries to purchase the organs they need to live.⁵⁶ In these markets, the absence of any regulation leaves both suppliers and recipients open to abuse. Suppliers may be paid too little and permanently damage their own health.⁵⁷ Recipients may pay too much, not get what they are paying for, and/or receive inadequate care. Gray and black markets also increase disparities based on socioeconomic class, which in the United States generally follows race. The rich, for example, can afford to travel abroad for a transplant or to bring an ostensibly uncompensated donor into the country for surgery, allowing them to buy their way out of domestic organ allocation systems and further exacerbating injustice in the allocation of body products.⁵⁸

The current legal regime, with its focus on supplier compensation in order to separate gifts from commodities, is failing to provide an adequate and justly allocated supply of many body products. The failure of gift regimes, such as that used for kidneys, leads to calls for commodification through markets (i.e., marketization). Marketization, as with gametes, leads to calls for compensation bans and/or regulation. Neither gift regimes nor commodity regimes seem sufficient. The dichotomy drives unresolvable debates while injustices

54. Lois D.W. Arnold & Laraine Lockhart Borman, *What are the Characteristics of the Ideal Human Milk Donor?*, 12 J. HUM. LACTATION 143, 143-44 (1996); *Donor Human Milk: Ensuring Safety and Ethical Allocation*, HUM. MILK BANKING ASS'N OF N. AM., <https://www.hmbana.org/sites/default/files/images/position-paper-safety-ethical.pdf> [<https://perma.cc/RNW3-39B9>].

55. ALMELING, *supra* note 13, at 44-45, 127-133; Krawiec, *Sunny Samaritans*, *supra* note 53, at 60. Note that there is also racially discriminatory pricing of gametes. ALMELING, *supra* note 13, at 69.

56. GOODWIN, *supra* note 1, at 10-12; I. Glenn Cohen, *Transplant Tourism: The Ethics and Regulation of International Markets for Organs*, 41 J.L. MED. & ETHICS 269, 269, 280 (2013).

57. See generally Kate Greasley, *A Legal Market in Organs: The Problem of Exploitation*, 40 J. MED. ETHICS 51 (2012); Nancy Scheper-Hughes, *Commodity Fetishism in Organs Trafficking*, 7 BODY & SOC'Y 31 (2001).

58. GOODWIN, *supra* note 1, at 10-11; Cohen, *supra* note 56, at 280.

continue. These debates seem unresolvable, in part because “[p]eople harbor strong moral intuitions against buying and selling human organs.”⁵⁹ This intuition is grounded in the standard narrative, a way of understanding the gift/commodity dichotomy in terms of a moral hierarchy.

III. THEORIZING BODY PROPERTY

Given these concerns, the law and policy of body product exchange has drawn significant scholarly attention. With the moral intuitions against buying and selling so naturalized, however, this scholarship, while rich and fruitful in many ways, has also remained in part constrained by the gift/commodity dichotomy, operating either within it or in opposition to it. Existing scholarship regarding body products has drawn upon three broad theoretical critiques, each of which has built upon and/or responded to the others. First, law and economics scholars argued that markets are the most efficient mechanism for preference satisfaction and that therefore there was no need for mandatory gift exchange, even in areas traditionally considered removed from the market, such as parental relationships. In this view, sometimes called “universal commodification,” all property should be traded in markets.⁶⁰ Second, and in response, Margaret Radin distinguished propertization from marketization or commodification, drawing upon a Hegelian theory of personhood to postulate that the category of market-inalienability (gift) is crucially important to prevent the inappropriate marketization of everything.⁶¹ Third, scholars working within what has been called commodification scholarship have applied Radin’s marketization analysis and concept of “incomplete commodification” to multiple arenas.⁶² While these scholars prioritize human flourishing and personhood, they often draw on sociological deconstruction of the gift/commodity dichotomy to reject the standard narrative and consider how market alienability, that is,

59. Stephen J. Choi et al., *Altruism Exchanges and the Kidney Shortage*, 77 LAW & CONTEMP. PROBS. 289, 290, 292 (2014) (proposing intermediate transactions that emphasize altruism rather than compensation).

60. While babies are not “body products,” the marketization of babies has been considered the high-water market of the law and economics approach to marketization. See Elisabeth M. Landes & Richard A. Posner, *The Economics of the Baby Shortage*, 7 J. LEGAL STUD. 323, 337-46 (1978). For the term “universal commodification,” see RADIN, CONTESTED COMMODITIES, *supra* note 14, at xii-xiii, 2-6. Zelizer has called this approach “nothing-but,” as there is nothing but the market. ZELIZER, PURCHASE OF INTIMACY, *supra* note 13, at 78-81; see also Ertman, *For Both Love and Money*, *supra* note 13, at 1022-23.

61. RADIN, CONTESTED COMMODITIES, *supra* note 14, at 54-78; Radin, *Market-Inalienability*, *supra* note 15, at 1893-98, 1903-15; Radin, *Property and Personhood*, *supra* note 14, at 958-59. Note that Radin developed her theory considering a range of what she has called “contested commodities,” considering sex and children as well as body parts. See RADIN, CONTESTED COMMODITIES, *supra* note 14, at title.

62. Radin, *Market-Inalienability*, *supra* note 15, at 1917-18.

sales, might generate desirable benefits.⁶³ Roughly speaking, the first two approaches work within the dichotomy, and the third in opposition to it.

This Part uses the intellectual history of property to develop a new theoretical framework which is allied with the third approach as outside the gift/commodity dichotomy, and, like the second, is grounded in property theory that emphasizes personhood over efficiency. To do so, I first review the second and third approaches, emphasizing their commonalities, and then link them to much older historical debates about the functions of property in American law and society, as well as to developments in property theory over the last two decades. This intellectual history allows us to recognize body product exceptionalism within property law, policy, and scholarship as based on a historically contingent assumption that body products, as property, are narrowly and exclusively market property. Having articulated this assumption, we can then set body product exceptionalism aside in favor of a broader view of property in preparation for building a law of body products and markets that rests on new assumptions.

A. *Propertization and Marketization*

Writing only a few years after the passage of NOTA, Radin developed her influential theoretical justification for separating human bodies from markets by considering body products as one type of potential market-inalienable property.⁶⁴ In doing so, she highlighted the distinction between propertization and marketization. Market-transferability is a common, but not essential, feature of property.⁶⁵ Radin justified market-inalienable property rights using her theory of property as promoting human flourishing and personhood.⁶⁶ In developing this personhood theory of property, she drew upon a Hegelian distinction between “things external by nature” and “substantive constitutive elements of personality;” those items that must be alienable are in the former category, while those that must be inalienable

63. The most influential collection of commodification scholarship is RETHINKING COMMODIFICATION, *supra* note 1.

64. Radin, *Market-Inalienability*, *supra* note 15, at 1850-51, 1855-57; *see also* RADIN, *CONTESTED COMMODITIES*, *supra* note 14.

65. For a discussion of “commodification” and “marketization” as “old” and “new” terms for the process of making something market-alienable, *see* Ertman & Williams, *Preface*, *supra* note 10, at 2. For an example of market-inalienable property outside of the realm of human body products, *see* *Andrus v. Allard*, 444 U.S. 51, 63-64 (1979) (eagles legally killed and owned, but not lawfully saleable). I thank Greg Alexander for this example.

66. RADIN, *CONTESTED COMMODITIES*, *supra* note 14, at 54; Radin, *Market-Inalienability*, *supra* note 15, at 1851-52, 1903; Radin, *Property and Personhood*, *supra* note 14, at 957-59 (summarizing personhood perspective on property); *see also* Radin & Sunder, *Introduction*, *supra* note 1, at 10-12 (reflecting on Radin’s earlier work).

are in the latter.⁶⁷ This theory particularizes the inchoate moral repugnance with which many view sales of body products by locating the harms threatened from such sale in the commodification of “constitutive elements of personality,” such that there is “reduction of the person (subject) to a thing (object).”⁶⁸ Radin also identified the potential “domino effect” of talking about bodies in market terms that might lead to a general belief that not only a body product, but also the generosity with which it might be offered and the person who supplied it, were for sale—harms inflicted not only upon individual suppliers but on all humans, whose generosity and personhood were thereby devalued through commensurability with money.⁶⁹ Keeping body products market-inalienable would prevent these harms, thus preventing this type of property from undermining the general purpose of property to promote personhood and human flourishing.

Radin’s scholarship was informed by the contemporary congressional and medical debates about the desirability of people selling one kidney and attempts to encourage the post-mortem gifting of kidneys through organ donor registration programs. It was also a response to law and economics scholarship offering theoretical justifications for reliance on markets to allocate all resources. Responding to a certain historical moment in legal scholarship, this theory provided a firm grounding for the gift/commodity dichotomy and an argument for recognizing body products as property-at-law while also keeping them as market-inalienable property (i.e., an argument for NOTA).

Radin recognized that in our non-ideal world, restricting body product sales (that is, mandatory gifting) might be harmful to human flourishing, even as commodification was also harmful. This “double bind” arises from the reality that bans on sale might impose harms upon those with such limited resources that body product selling might be better than other options.⁷⁰ Her theory thus did not resolve the gift/commodity debate by unquestioning acceptance of the standard narrative of good gifts and harmful sales, nor attempt to justify maintaining all body products as market-inalienable property in all

67. Radin, *Market-Inalienability*, *supra* note 15, at 1893. Radin was careful to note that personhood theory did not rely on a simplistic internal/external division, but should consider “three main, overlapping aspects of personhood: freedom, identity, and contextuality” when identifying “personal things.” *Id.* at 1904-07. While Radin’s framing has been very influential, it is not without its critics, some of whom have taken issue with her interpretation of Hegel. *See, e.g.*, Jeanne Lorraine Schroeder, *Virgin Territory: Margaret Radin’s Imagery of Personal Property as the Inviolable Feminine Body*, 79 MINN. L. REV. 55, 114-33 (1994); *see also* GREGORY S. ALEXANDER & EDUARDO M. PEÑALVER, AN INTRODUCTION TO PROPERTY THEORY 57-69 (2012) (explaining Hegelian property theory).

68. Radin & Sunder, *Introduction*, *supra* note 1, at 8.

69. RADIN, *CONTESTED COMMODITIES*, *supra* note 14, at 95-101; Radin, *Market-Inalienability*, *supra* 15, at 1912-14; Radin & Sunder, *Introduction*, *supra* note 1, at 11.

70. Radin, *Market-Inalienability*, *supra* note 15, at 1915-17; *see also* RADIN, *CONTESTED COMMODITIES*, *supra* note 14, at 123-24.

circumstances. Instead, it provided a justification for the market-inalienable category in the face of calls for universal commodification and a means for analyzing when the law should mandate market-inalienability by weighing the possible harms of commodification and the existence of the double bind with respect to each particular body product.

As has been pointed out by subsequent scholars and further developed by Radin herself, this theoretical framework, insofar as it applies to body products, rests on two assumptions. First, that the domino effect is a real threat, because gifting and selling not only occur in separate mutually exclusive spheres, but also because there is a tendency for the market sphere to overwhelm the non-market sphere once a market is established.⁷¹ Second, that body products are not “things external by nature” but “constitutive elements of personality,” such that their sale is always harmful as an objectification of the human subject.⁷² In work that joins Radin’s project of recognizing property and regulating its transfer in order to promote human flourishing and personhood, commodification scholars have examined these assumptions in order to consider whether body products might be market alienable in ways beneficial to the supplier, rather than merely less harmful than mandatory gifting.⁷³ Testing the second assumption, they have asked whether there is always a double bind or whether market alienability might occur while the supplier remained the subject of commodification, creating property “external by nature” through disembodiment and actualizing its value without the supplier becoming the object of commodification herself.⁷⁴ Returning to the first assumption, they have also questioned whether sales and market rhetoric surrounding body products lead inexorably to troubling commodification of motivation and identity.

Just as Radin’s pioneering work developed within the intellectual context of legal scholarship, subsequent scholars were informed by Viviana Zelizer’s path-breaking work in sociology of markets that began to reach a wider academic audience in the 1980s and 1990s.⁷⁵ This work used historical examples to disrupt the idea of separate, mutually exclusive, spheres of market relationships and intimate relationships and provided a theoretical framework for opposing the standard narrative and the gift/commodity dichotomy. More recent

71. See, e.g., RADIN, *CONTESTED COMMODITIES*, *supra* note 14, at 46-53, 103 (explaining and rejecting spatial metaphor of market and non-market); Joan C. Williams & Viviana A. Zelizer, *To Commodify or Not to Commodify: That is Not the Question*, in *RETHINKING COMMODIFICATION*, *supra* note 1, at 362.

72. Radin, *Market-Inalienability*, *supra* note 15, at 1893.

73. This scholarship is collected in *RETHINKING COMMODIFICATION*, *supra* note 1.

74. Radin & Sunder, *Introduction*, *supra* note 1, at 11-12.

75. Ertman, *For Both Love and Money*, *supra* note 13.

sociological studies concerning body product exchange in the late twentieth- and early twenty-first-century United States have demonstrated that cash exchanges and gift narratives coexist. Emotions such as altruism and attachment intermingle with exchange value and compensation in ways both chosen by participants and shaped by institutional narratives crafted to explain body product transfer.⁷⁶ This scholarship provides evidence that the domino effect is not inevitable, and that some body product sellers consider body products as “things external to themselves,” the sale of which does not threaten their personhood.

This work reveals that Radin’s initial move to examine “contested commodities” as part of property theory rather than via the narrower question of marketization is foundational. It is necessary to focus on the question of whether and how body products are property (proptertization) rather than whether they should be saleable (marketization). Yet commodification scholarship has suggested that the division between market-alienable and market-inalienable property, while easy to enact in law, is not necessarily key to participants in body product exchanges. That raises the significant question: how then should we characterize body products as property?

B. *Property and Body Products*

Answering this question requires us to consider the intellectual history of property theory, and in so doing, better understand the theoretical origins of the gift/commodity dichotomy in legal scholarship. This history reveals property’s incoherencies and the multiple purposes it is asked to serve in American law and political philosophy. It also reveals that a focus on proptertization does not avoid the question of markets. In his investigation of the “meaning of property,” Jedediah Purdy starts from the observation that all property is “intimately tied to markets.”⁷⁷ The nature of those ties, like much else about property, has long been contested. Purdy has argued that property is necessarily incoherent and resists a grand unifying theory because it serves two conflicting ends in political philosophy: to provide the basis of social order and to provide the basis of personal freedom.⁷⁸ How these conflicting ends are understood, and at least partially reconciled, has much to do with markets.

Because of the obvious ties between body products and the individual self, the arguments for separating body products from markets tend to focus on the purpose of property to promote human freedom,

76. ALMELING, *supra* note 13 (gametes); HEALY, *supra* note 13 (blood and organs).

77. JEDEDIAH PURDY, *THE MEANING OF PROPERTY: FREEDOM, COMMUNITY, AND THE LEGAL IMAGINATION* 4 (2010).

78. *Id.* at 9-11.

what Purdy calls the “master value.”⁷⁹ If we follow Purdy in analyzing human freedom along three axes of “choice without interference, a rich set of alternatives, and the subjective capacity to identify and pursue interests and projects,” then recognizing property in human bodies may implicate all three.⁸⁰ Having money on offer for body products in a world in which a rich set of alternatives and the capacity to pursue interests and projects are unequally distributed means that those who are already lacking in these aspects of freedom to act will be unable to choose to sell their body products without interference. Their more urgent need for resources to access such alternatives and capacities interferes with their ability to make a free choice about propertizing their bodies. From this perspective, if body products are property, sales of such property must be banned for such property to advance (rather than to impede) personal freedom. Banning such sales while allowing gifting protects the disadvantaged from acting in unfree ways. This argument is consonant with Radin’s argument that body parts should be market-inalienable to preserve personhood and human flourishing, and with her argument that such market-inalienability may create a double bind.

If we take a different perspective on markets, however, we can use property theory to explain the propertization of body products quite differently, even while still focusing on the master value of personal freedom. The ability to harvest body products from oneself for sale can be grafted onto the classic liberal tradition of property as enhancing personal freedom by providing the ability to participate in markets. In this tradition, as developed in American law and politics during the nineteenth century through the concept of freedom of contract, the ability of every human to sell one’s labor is a cornerstone of both industrial capitalism and individual freedom. Recognizing property in one’s hair, blood, or semen becomes simply another aspect of this tradition. It provides all individuals with additional unconstrained choices of property to sell or give away, and thus enhances their ability to access a rich set of alternatives and to pursue individual projects. While allowing someone else to take property from one’s body would be to deny the exclusive right of ownership at the core of both property theory and the liberal individual self, to grant property rights to the supplying body does not. Freely alienable property in the human body can thus be seen as constitutive of human freedom in ways that promote human flourishing.

Thus far, this discussion of property and its purposes has proceeded based on the assumption that we are discussing what Purdy calls

79. *Id.* at 4.

80. *Id.* at 11.

“liberal property.”⁸¹ Classic liberal political theory assumes that property is that which can be traded in markets. Trading property in markets supports and reconciles the two oft-conflicting ends of property: social order and individual freedom. It provides the basis of personal freedom by allowing individuals to express their preferences through the marketplace by property exchange, and provides the basis of social order by giving the state its purpose, made manifest through law, to protect the freedom to exchange property.⁸² Social order is created and maintained to preserve individual freedom through the institution of property. From this perspective, the question of whether body products should be recognized as property-at-law leads immediately to the question of their free exchange in markets, the answer to which depends on which of the preceding two narratives is more persuasive. The assumption that all property is liberal property has led courts to deny property status to body products so as to avoid their free market exchange and has led legislatures (as a matter of policy) and Radin (as a matter of theory) to place body products in a special category of property that is prohibited from market exchanges.⁸³ The gift-versus-commodity divide and the domino effect assume liberal property.

There is more than one understanding of property within American political philosophy and law, however, and like the gift/commodity dichotomy and the category of market-inalienability, liberal property is not an unchanging, timeless concept. Gregory Alexander has traced the detailed intellectual history of property in American law as not only theoretically riven by its conflicting duties to serve social cohesion and individual freedom, but also as further divided into two separate philosophical traditions that take different approaches toward balancing those duties.⁸⁴ Rather than commodity versus gift, Alexander has taught us about commodity versus propriety, or, in twenty-first-century terminology, ‘market property’ versus ‘civic property.’⁸⁵ The commodity, or market, perspective considers property to be that which is exchanged in markets. Market property acts as a means of satisfying individual preferences, creating the ba-

81. *Id.* at 4.

82. *Id.* at 9-11.

83. I do not mean to suggest that Radin argues that all body products should be market-inalienable in all circumstances; she does not. RADIN, CONTESTED COMMODITIES, *supra* note 14, at 107, 126, 161.

84. In subsequent work, Alexander has sought to reconcile the conflicting ends of property. See, e.g., Alexander, *Property's Ends*, *supra* note 16, at 1260.

85. ALEXANDER, COMMODITY AND PROPRIETY, *supra* note 16, at 1. Alexander uses “market” and “civic property” interchangeably with his preferred terms, “property-as-commodity” and “property as propriety.” *Id.* at 1-3, 384. Because the term ‘commodity’ is already in use as part of body product scholarship, to avoid confusion I use ‘market property’ and ‘civic property’ rather than property-as-commodity and property as propriety.

sis of social order through market exchanges. When Purdy discusses “liberal property,” he is assuming market property.⁸⁶

In the second half of the twentieth century, the market property conception came to dominate American legal thought as part of the triumph of the market in the American liberal tradition, the same triumph that brought economic analysis to prominence within American legal scholarship.⁸⁷ Since 1970, contemporaneous with the development of the standard narrative and the gift/commodity dichotomy, as well as the dominance of law and economics discourse, both legal scholarship and court opinions “c[a]me to reflect the idea that the basic, if not the sole, purpose of property is the satisfaction of individual preferences through market transactions.”⁸⁸ The assumption of a market property understanding became so broadly shared as to be almost invisible. Body products, as they became considered property-in-law during this period, were viewed through the lens of market property, because all property was being viewed through this lens.

From a civic property perspective, however, the relationship between body products, markets, and property shifts. The civic property perspective differs by prioritizing a normative vision of the public good and considering property creation and exchange, both market and non-market, as a means of advancing that vision, thereby promoting both individual freedom and social order.⁸⁹ The essence of civic property is its role linking private property and private interests to the polity as a whole, reconciling the potential conflict between the twin aims of human freedom and social order in a way that acknowledges, but does not prioritize, the market. Rather than beginning with the market as the institution of human freedom, civic property requires “some prior normative vision of how society and the polity that governs it should be structured,” which defines the public good.⁹⁰ This understanding of property was prevalent in the colonial era and

86. See generally PURDY, *supra* note 77.

87. ALEXANDER, *COMMODITY AND PROPRIETY*, *supra* note 16, at 379-83; RADIN, *CONTESTED COMMODITIES*, *supra* note 14, at xi (considering contested commodities within the “modern market society”). From here forward, I will use Alexander’s term “market property” rather than “liberal property.”

88. ALEXANDER, *COMMODITY AND PROPRIETY*, *supra* note 16, at 379.

89. *Id.* at 1-3, 6, 384-85; see also Carol M. Rose, Mahon *Reconstructed: Why the Takings Issue Is Still a Muddle*, 57 S. CAL. L. REV. 561, 591-94 (1984) (describing early republic origins of civic property and its persistence in American legal thought); Carol M. Rose, “Takings” and the Practices of Property: Property as Wealth, Property as “Propriety,” in PROPERTY AND PERSUASION: ESSAYS ON THE HISTORY, THEORY AND RHETORIC OF OWNERSHIP 49 (1994). Laura Underkuffler has described a similar division in the understanding of property between “broad” and “narrow” that mirrors Alexander’s historical argument. Laura S. Underkuffler, *On Property: An Essay*, 100 YALE L.J. 127, 128-29 (1990).

90. ALEXANDER, *COMMODITY AND PROPRIETY*, *supra* note 16, at 2.

the early republic but has waned since the eighteenth century as the United States increased in population and diversity.⁹¹

Alexander, however, has also noted that despite the dominance of market property, the dialectic between civic and market conceptions of property has continued throughout the twentieth century and into the twenty-first, as has the attempt to reconcile community-oriented purposes (the public good) and private preferences (possessive individualism) when considering the law and policy of property.⁹² Most American lawyers and policy makers accept that “there is no inherent contradiction between the institution of private property and a regulated economy;” that is, that markets, and the ability to exchange property in markets, are in some ways subordinated to a conception of the public good enacted by legislatures and agencies.⁹³ What is remarkable with respect to the law of body products, and so much of the public debate surrounding their exchange, is that the law and these debates not only assume market property, but also an extremely narrow and rigid view of market property, as if there were a contradiction between property in body products and regulated markets. They assume that if body products are recognized as property, they will be market property traded solely to satisfy individual preferences and that wealth-maximization will drive such exchanges, leading to coercive and corruptive harms, such as those seen in unregulated black markets in organs.

Despite the prevalence of regulation of other commodities, when it comes to body products there has been little room for thinking about how the public good might be promoted through regulated markets. Thus, the recent proposal to compensate bone marrow donors with a flat fee of \$3,000 in the form of scholarship money, housing subsidy, or charitable donation encountered legal opposition as impermissible under NOTA, and Mother’s Milk Cooperative’s offer of money for breast milk provoked sharp criticism that the offer was too likely to lead to nursing mothers depriving their own babies, despite the recognized shortage of breast milk for sick infants.⁹⁴ This assumption that if regarded as property-in-law, body products must be not only market property, but also market property traded in unregulated markets, is a form of body product exceptionalism. This exceptionalism underlies the gift/commodity dichotomy, the standard narrative, NOTA, and much of the debates about body product exchange. Like the narrative itself, it needs to be disrupted.

91. *Id.* at 1-2, 4-5.

92. *Id.* at 384-85.

93. *Id.* at 361.

94. For the breast milk controversy, see Kozlowski, *supra* note 8; for bone marrow proposal, see *Flynn v. Holder*, 684 F.3d 852, 858 (9th Cir. 2012); Brief of Appellants at 8-9, *Flynn*, 684 F.3d 852 (No. 10-55643).

Recognizing this exceptionalism allows a rethinking of body products as property. We can replace the question of market alienable or market inalienable, which has been circumscribed by this narrow market vision of property, with the question of what purposes body products as property should serve. Relinquishing body product exceptionalism allows consideration of the marketization of body products not as the endpoint to be evaluated in terms of the threatened harms of gifts versus the threatened harms of sales, but as a possible beneficial means toward achieving progressive goals. In the twenty-first century, the long-standing civic property tradition is being reworked in multiple ways by legal scholars, opening up theoretical and practical possibilities in balancing or reconciling the public and private ends of property—possibilities that bear exploration when thinking about regulating body products as property.⁹⁵

Parts IV and V provide groundwork for that exploration by identifying body product exceptionalism in theory and practice as a recent historical construct that is not due to an inherent difference between body products and other forms of property. The history of body products as property-in-action reveals that body products were first developed and used as a form of civic property. They were bought and sold in service of a medically defined notion of the public good. Alexander used the writings of American legal thinkers to trace the civic property tradition and its dialectical relationship with market property.⁹⁶ To analyze body products as property-in-action and complete the denaturalization of the gift/commodity dichotomy, I examine the words and actions of a different community, a community that was not engaged in a discussion of what the law ought to be, or even what sort of civil society the United States ought to foster, but rather in a discussion of what it meant to be a medical professional.

IV. BODY PRODUCTS AS CIVIC PROPERTY-IN-ACTION

Doctors first created body products to treat patients. By analyzing the actions and statements of medical professionals to understand the early relationship between body products and markets, I am working in the tradition of a law and society approach to legal history, considering law as it arises out of community practices as well as analyzing statutes and judicial decisions.⁹⁷ I also draw upon a distinction often explored in law and society scholarship between law-in-books and law-in-action.⁹⁸ Analyzing this history through the lens of

95. See *supra* note 17 and accompanying text.

96. ALEXANDER, *COMMODITY AND PROPRIETY*, *supra* note 16, at 15.

97. This form of legal history owes much to the pioneering work of J. Willard Hurst. Christopher Tomlins, *Engaging Willard Hurst: A Symposium*, 18 *LAW & HIST. REV.* xiii (2000).

98. This distinction was analyzed by Roscoe Pound, *Law in Books and Law in Action*, 44 *AM. L. REV.* 12 (1910), and further theorized in subsequent law and society scholarship.

property theory reveals that as doctors acquired, stored, and sold the first body products, human milk and blood, they were creating property-in-action.⁹⁹ Further, their perspective toward this new property can best be described as a civic property view, although theirs was a medicalized vision of civic property. The doctors had a clear normative vision underpinning the use of this new property. In the first decades of using these body products, they relied on market exchanges to manage body products in the service of three interrelated goals: (i) to generate adequate and safe supplies of body products for use in medical treatment; (ii) to provide body products to all patients who needed them, not just those who could afford to pay; and (iii) to provide compensation to suppliers sufficient to encourage repeat sales, gain compliance with safety-related measures, and, in some instances, promote the health and well-being of the suppliers themselves. In this civic property-in-action framework, in which market exchanges were assumed to be in the service of these tripartite goals, the question of gift versus commodity simply did not arise.

A. *Medical Professionalism and Markets*

The medical vision of body products as civic property-in-action was a result of both the medical profession's self-conception and the dominant means of allocating and financing medical care at the turn of the twentieth century. Doctors facing patients needing treatment asked themselves intensely practical and urgent questions.¹⁰⁰ How were they going to get body products to use in treatment, who was going to pay for them, and who would receive these new treatments? These questions arose in a new context when the human body became the source of desired therapeutics, but they were informed by long-standing tensions within the medical community, arising out of doctors' desire both to be recognized as professionals and to make a living from practicing medicine.

Formally trained doctors labored throughout the nineteenth and twentieth centuries to establish the medical profession as the authoritative source of medical treatment.¹⁰¹ As part of their understanding

See, e.g., David Nelken, *Law in Action or Living Law? Back to the Beginning in Sociology of Law*, 4 LEGAL STUD. 157 (1984) (tracing Pound's influence on sociological studies of law).

99. For previous uses of the concept of property-in-action, see generally, for example, John A. Lovett, *Progressive Property in Action: The Land Reform (Scotland) Act 2003*, 89 NEB. L. REV. 739 (2011); Sidney Post Simpson, Book Review, 49 HARV. L. REV. 1211, 1215 (1936) (reviewing C. REINOLD NOYES, *THE INSTITUTION OF PROPERTY* (1936)).

100. More detailed discussion of the history described below can be found in SWANSON, *supra* note 4, as well as in the historiography referenced *infra* in the notes to Part IV.

101. Formally trained doctors competed with a wide range of other practitioners in a medical marketplace in which patients could, and did, seek multiple forms of care. While the medical profession was significantly organized by the turn of the twentieth century, it was

of their profession, doctors endorsed the idea that they were called to serve those who needed their attention, in ways that a shoe manufacturer, for example, is not called by professional ethics to provide shoes for the barefoot. Nor did doctors think of themselves as selling their time like the laborer in the shoe factory. As professionals, doctors sold their expertise rather than products or labor. This ideal of service and the primacy of expertise, cornerstones of the successful move to professionalize medicine, have always been in tension with the desire of many doctors to make a living by practicing medicine, and hence, with the ways in which medical care is allocated and compensated.¹⁰²

The initial impetus for developing the first body products was primarily patients, not profits.¹⁰³ In the early stages of using body products, doctors were not thinking about managing markets or even about creating a reliable source of supply. Faced with a patient needing medical care, doctors sought access to the body product they thought might help in an ad hoc manner. Doctors arranged sources of bottled human milk to save the lives of premature and sick infants, and sought blood suppliers to aid their efforts to resuscitate patients “sinking . . . into the grave” from blood loss.¹⁰⁴ When possible, they looked for unpaid volunteers among those close at hand, but doctors had no qualms about turning to cash as an obvious inducement to persuade a healthy person to give up a body fluid to another. Body

not until the mid-twentieth century that it reached significant power, prestige, and wealth. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 7-8, 80-81 (1982).

102. STARR, *supra* note 101, at 235-36. Note, too, that there is a distinction between “medical ethics,” the formal ideals of the profession, and “medical morality,” the actual standards of conduct within the medical community. ROBERT BAKER, *BEFORE BIOETHICS: A HISTORY OF AMERICAN MEDICAL ETHICS FROM THE COLONIAL PERIOD TO THE BIOETHICS REVOLUTION* 4 (2013).

103. While not discounting the desire of doctors to get paid, I found no evidence in my historical research that any of the pioneering doctors sought to, or did, earn a premium from their innovations with blood or milk. *Cf.* Kara W. Swanson, *The Doctor’s Dilemma: Paternalisms in the Medicolegal History of Assisted Reproduction and Abortion*, 43 *J.L. MED. & ETHICS* 312, 314 (2015) (early fears of profiteering in providing access to donor semen). There was no question of asserting intellectual property in these new methods or therapeutics and no attempts by doctors to create commercial entities. Kara W. Swanson, *Human Milk as Technology and Technologies of Human Milk: Medical Imaginings in the Early Twentieth-Century United States*, 37 *WOMEN’S STUD. Q.* 20, 29-32 (2009) [hereinafter Swanson, *Human Milk as Technology*] (describing medical opposition to patented method for preserving human milk). Doctors did choose in some instances to publish their experiments and results in medical journals and via professional conferences. In an era before fee schedules, this common means of communication in the field could enhance professional prestige and thus, secondarily, possibly increase patient demand and the ability to charge higher fees.

104. JAMES BLUNDELL, *THE PRINCIPLES AND PRACTICE OF OBSTETRICY AS AT PRESENT TAUGHT* 349 (London, E. Cox, 1834). The published reports by Blundell, an English doctor, of his success using transfusion to treat postpartum hemorrhage stimulated renewed interest in transfusion in the nineteenth-century United States. SWANSON, *supra* note 4, at 26.

products would never have become established as therapeutics without willing sellers and doctors acting as brokers.

The doctors who first used body products treated them as property of the suppliers; a good that could be purchased and allocated as the purchaser saw fit. Body products were thus property-in-action from their origins in medical treatment. Further, as property-in-action, body products were also immediately commodities in that they were exchanged for cash. They were not merely market property, however, because they were not bought and sold in profit-maximizing individual transactions. When doctors acted as purchasers or brokers, they did so while maintaining the professional ideal of offering expertise as a service. They were not profit-maximizing manufacturers or tradesmen producing a good.

In order to exercise their expertise, doctors wanted a safe and adequate supply of body products that they could use to treat any patient as necessary. The ideal of service, however, complicated this aspect of their vision of body products as property.¹⁰⁵ What if a needy patient could not afford the treatment? The professional dilemma that had always existed when a patient could not afford to pay for care became more acute when the needed therapeutic was under the control of a third party, a healthy stranger. For over a century, many American doctors had provided care to some patients for free; the hospital was originally a site of charity care for the indigent. Doctors might treat charity patients on some days and spend the remainder of their time treating private patients.¹⁰⁶ Some of the pioneering doctors strove to manage that conflict in the context of body products by controlling the supply and allocating it in their discretion among the medically needy, which included both patients who could afford to pay and those who could not. By shifting ownership from suppliers to the doctors, doctors could better ensure allocation based on need rather than solely on ability to pay. Propertization thus could advance the second aspect of their vision of the public good to be served by body product exchange, providing treatment to all who needed it.

Some of these doctors promoted an even more encompassing vision of the public good. In addition to the ability to practice using the most effective treatments and to provide care to all medically needy, they

105. During the first decades of the twentieth century, the medical profession was overwhelmingly, although not completely, male. It was also largely white. ELLEN S. MORE, *RESTORING THE BALANCE: WOMEN PHYSICIANS AND THE PROFESSION OF MEDICINE, 1850-1995* 3-5 (1999). The homogeneity of the profession in terms of race, class, and gender unquestionably influenced medical ethics and norms, as well the practices of body product exchange.

106. CHARLES E. ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM* 338-41 (John Hopkins Univ. Press 1995) (1987); Swanson, *Human Milk as Technology*, *supra* note 103, at 24 (describing how Dr. Fritz Talbot, an early twentieth-century pediatrician, treated both private and charity patients).

also imagined that in creating this new supply chain, in which healthy human bodies became the source of new treatments, they might advance the public health by promoting the ability of suppliers to care for themselves and their families and remain healthy. They thus added a third aspect to their vision of body products as civic property-in-action.

Although the purchase and sale of human milk and blood as body products developed differently, in each case doctors relied upon what became known as “professional donors”—people willing to sell their body products regularly and repeatedly as a means of supporting themselves and their families. With each body product, doctors then strove to establish and manage paid body product exchanges in ways that promoted their vision of the public good.

B. Selling Mothers' Milk as a “Double Charity”

Human milk was the first body product collected systematically by doctors in the first years of the twentieth century. Breast milk was the safest form of nutrition for babies at a time before pasteurization and mechanical refrigerators. In its embodied form, human milk had long been the object of monetary exchanges through the service of wet nursing.¹⁰⁷ Traditionally, paid American wet nurses were unmarried women, often immigrants, who were willing to wean and board out their own child (at great risk to its life) in order to work as a live-in servant whose duties included breastfeeding and basic infant care.¹⁰⁸ As industrialization increased the options for women to earn wages, fewer women found wet nursing appealing.¹⁰⁹ During these same decades, doctors focused on infant nutrition as the best way of reducing mortality among their tiniest patients. Although there were multiple “artificial feeding” options, many doctors believed that premature infants and sick infants survived best when fed human milk.¹¹⁰ These doctors began to consider breast milk in bottles superior to wet nursing.

Wet nurses were not only increasingly difficult to find at the turn of the twentieth century, but they also had the failing that doctors and parents could not monitor the quantity or quality of milk they provided to a patient. Beginning in 1910, one energetic young Boston doctor, Fritz Talbot, envisioned improving medical control over this

107. FILDES, *supra* note 3.

108. This description applies to free women. In the antebellum south, slave women might serve as unpaid wet nurses. GOLDEN, *supra* note 3, at 25-27.

109. *Id.* at 136-40.

110. RIMA D. APPLE, *MOTHERS AND MEDICINE: A SOCIAL HISTORY OF INFANT FEEDING, 1890-1950* 6-11 (1987); GOLDEN, *supra* note 3, at 134-36; SYDNEY A. HALPERN, *AMERICAN PEDIATRICS: THE SOCIAL DYNAMICS OF PROFESSIONALISM, 1880-1980* 46 (1988).

form of infant nutrition by inducing lactating women to express their milk, which could then be examined for quality, processed into bottles, and dispensed in known quantities to his patients. Early experiments in Boston, in which a nurse traveled from home to home in a reverse milk route collecting each mother's contribution and paying her by the ounce, were successful in creating a supply of disembodied breast milk that Talbot and his fellow pediatricians could allocate amongst the sickest babies. Doctors in Boston and elsewhere expanded upon this initial effort by creating "mothers' milk stations," institutions that purchased milk from lactating women, combined the milk into a uniform product, pasteurized it, and resold it in bottles to patients.¹¹¹ Now a body product, human milk as a good replaced the service of wet nursing.

Talbot had started with the goal of developing a safe and adequate supply of this therapeutic for his patients that would be more reliable, efficient, and controllable than the wet nurse. He used money to induce women to provide this product. Talbot and his colleagues thought carefully about the way they bought and sold milk. The doctors who established these institutions in cities across the United States did not see the markets they were creating as primarily satisfying the individual preferences of the market participants. Rather, the flow of money and milk were a means of fulfilling a medical vision of the public good.

For example, Dr. Raymond Hoobler developed the first mothers' milk station in New York City in 1913. He experimented to determine how little he could offer mothers to get a reliable supply of raw milk, striving to create an inventory at the lowest per ounce cost possible.¹¹² When women came daily to the station to express milk on site, it was not only more efficient than a reverse milk route, but the station nurse could, and did, supervise the women in washing themselves and expressing the milk, which promoted the safety of the resulting body product. Hoobler's goal in keeping his cash outlay as low as possible while meeting demand and safety concerns, however, was not to buy low and then to sell the finished product for as much as the market would bear. Rather, his "sincere desire [was] to increase the supply of human milk available for feeding the sick children in the wards and dispensary of Bellevue Hospital," many of whom were receiving free care as charity cases.¹¹³ By keeping supplier pay-

111. GOLDEN, *supra* note 3, at 184-89; Janet Golden, *From Wet Nurse Directory to Milk Bank: The Delivery of Human Milk in Boston, 1909-1927*, 62 BULL. HIST. MED. 589 (1988); Swanson, *Human Milk as Technology*, *supra* note 103, at 26-27.

112. B. Raymond Hoobler, *An Experiment in the Collection of Human Milk for Hospital and Dispensary Uses*, 31 ARCHIVES PEDIATRICS 171, 172 (1914) [hereinafter Hoobler, *An Experiment*].

113. *Id.* at 171.

ments low, Hoobler could keep charges to patients low, increasing the number of sick babies who could access this potentially life-saving therapeutic.

Hoobler later moved to Detroit and operated a mothers' milk station there through the 1920s. At the Detroit station, administrators sought to meet expenses, but had no expectation of profits. Hoobler used a sliding fee scale to charge for the bottled milk. Rates up to thirty cents per ounce paid by the well-to-do financed free bottles for impoverished families of sick infants.¹¹⁴ Bottled milk was a commodity traded in markets, but it was created and traded to serve a particular medical vision that combined doctors prescribing milk in their professional expertise with treating all who needed milk. By treating disembodied breast milk as property-in-action that was owned and controlled by the station, the doctors were able to promote both goals.

Further, milk station administrators saw an opportunity to enhance the lives of their suppliers and the suppliers' children. The selling women had recently been obstetrical patients themselves, and were responsible for the health of their infant and often other children. While Hoobler had experimented with the lowest cost per ounce that he could offer sellers in New York City, he recognized that he needed to offer enough to motivate these women to travel to the station daily to sell milk and to choose to continue lactating rather than weaning their newborn in order to seek wage labor outside their homes. Because women who chose to sell milk continued to nurse their own infants and to remain home to care for them, as well as any other children they might have, Hoobler called his milk-buying scheme a "double charity."¹¹⁵ While supplying his infant patients, Hoobler was offering the selling mothers and their children not only wealth, but also improved health outcomes.

The "double charity" model encompassed more than cash payments. The New York milk sellers also received free medical check-ups for themselves and their babies and advice on nutrition and baby care. While the medical check-ups helped maintain the safety of the milk and ensured that the women were not stinting their own infants, such postpartum care and well-baby visits were benefits in an era before health insurance that also greatly increased the chances that those families would thrive. In Chicago, selling mothers also received cow's milk as a nutritional supplement every time they expressed milk, which bolstered their health.¹¹⁶ When describing the mothers' milk station in Boston in the 1930s, Talbot explained that

114. B. Raymond Hoobler, *Human Milk: Its Commercial Production and Distribution*, 84 JAMA 165, 165 (1925).

115. Hoobler, *An Experiment*, *supra* note 112, at 172-73.

116. *Saving Lives with Mothers' Milk*, 18 HYGEIA 424, 425-28 (1940).

caring for the supplying mothers, their babies, and other members of their families had become “one of the important branches of the work.”¹¹⁷ By 1943, when the American Academy of Pediatrics issued formal guidelines for managing a mothers’ milk station, the guidelines stated: “Regular milk donors should receive compensation sufficient to insure good standards of living and relief from financial worry.”¹¹⁸ Supplier compensation was medically recommended as a means of benefiting, rather than exploiting, suppliers.

Through the mothers’ milk station, disembodied breast milk became property-in-action. The doctors who prescribed it, the women who sold it, and families who bought it to feed to their babies assumed it to be property. It was a market commodity in that it had a per-ounce value, but it was created and distributed by medical professionals to serve particular ends. In action, bottled breast milk was not classic market property, but a form of civic property. Doctors managed purchases and sales in order to control and allocate human milk in their professional discretion. Through market exchanges, they furthered their long-standing professional vision of using their expertise to treat those who sought their help. Creating medical therapeutics sourced from human bodies created opportunity for exploitation—for example, women neglecting their own nurslings by selling too much milk—but also created an opportunity to replace a system of wet nursing premised on neglect of the nurse’s child. In a non-ideal world involving many women and children without access to adequate healthcare, doctors created this new property to serve their “double charity” vision of the public good, using propertization and markets to improve the health of the seller as well as the recipient.

C. Professional Blood Donors

During the same decades that pediatricians were establishing mothers’ milk stations, other doctors were working to save lives by blood transfusion. Physiologically, it was challenging to make human blood into a disembodied body product. The technical difficulties led doctors to create a different sort of institution: blood donor registries. These doctors too used money to motivate sellers in order to create a safe and adequate supply. The early blood sellers, however, were more like traditional wet nurses than the new milk sellers. The registries created by doctors and hospitals were lists of people willing to sell their blood on demand at a patient’s bedside, like the wet nurses who would travel to the baby’s home. Relying on the prompt availa-

117. Fritz B. Talbot, *Introduction to Cornelia H. Macpherson, Standards for Directories for Mother’s Milk*, 15 J. PEDIATRICS 461, 461 (1939).

118. Comm. on Mothers’ Milk, Am. Acad. of Pediatrics, *Recommended Standards for the Operation of Mothers’ Milk Bureaus*, 23 J. PEDIATRICS 112, 113 (1943).

bility of what became known as “professional donors,” doctors could use their expertise to decide when to perform transfusions. The blood, however, remained embodied until immediately before use and was sold directly from supplier to patient, with patients required to pay the fee. These first blood markets thus treated blood more as market property-in-action than civic property-in-action. Without medical ownership and control of the blood supply, doctors could not manage its exchange to serve their professional ideal of providing treatment without regard to ability to pay. This limitation drove some doctors to reconceive the blood supply system in order to transform it from market property-in-action to civic property-in-action.

Before blood could become any form of property-in-action, doctors needed to learn how to perform blood transfusion safely and effectively, a process that was much more complicated and dangerous than feeding a baby milk from a bottle. Blood transfusion had been a medical dream since the early modern period, but several centuries of effort had not resulted in much success by the early twentieth century.¹¹⁹ Medical experimenters made rapid progress during the first two decades of the century, however. By the 1910s, blood transfusion, though still uncommon, was becoming more routinely successful.¹²⁰ The ability to keep blood outside the body briefly without clotting made blood into a body product, susceptible to being treated as property.

As transfusion became more safe and effective, doctors faced the problem of developing an adequate supply of blood. The blood supply problem was a problem of supplier recruitment, similar to the problem pediatricians had faced earlier when relying on hard-to-find wet nurses. There was no tradition of providing blood comparable to wet nursing, however, nor an obvious target population, like lactating women, from which to recruit blood suppliers. Like the pediatricians who set up mother’s milk stations, surgeons began with the assumption that cash was the best inducement. They were happy to take family members as unpaid volunteers, if available, but if not, money turned strangers into blood suppliers. A young surgeon in Baltimore offered a recovering patient \$100 to serve as his first blood supplier.¹²¹ As with human milk, blood sales were not taboo, but rather an unproblematic necessity.

The registry system, a technique that had also been used for wet nurses, made supplier recruitment more efficient. The registered suppliers were screened for medical problems, such as malaria or syphilis, both of which could be transmitted via a transfusion. Once blood

119. LEDERER, *supra* note 4, at 34-39.

120. *Id.* at 41-48; SWANSON, *supra* note 4, at 29-30.

121. BERTRAM M. BERNHEIM, ADVENTURE IN BLOOD TRANSFUSION 8 (1942); LEDERER, *supra* note 4, at 45-46, 80-81.

group matching became routine in the 1920s, the blood type of registered sellers was also recorded.¹²² The registered professional donors offered advantages over ad hoc unpaid volunteers. There was no wait to determine blood type and no need to rely on hastily given assurances of good health in a context where it could be awkward for a family member to admit to a syphilis infection. Some hospitals, such as the Mayo Clinic, maintained their own registry.¹²³ Other hospitals outsourced the work of recruiting suppliers to for-profit registries.¹²⁴

While the registry provided a safe and adequate supply, the market property version of blood as property-in-action posed an increasing problem as blood transfusion became common by the 1930s. Professional donors were convenient, but they were too expensive for poorer patients.¹²⁵ If a charity patient lacked a suitable volunteer, and the treating hospital was unwilling to bear the expense of a professional donor, the patient could not receive blood and might die as a result.¹²⁶ Pediatricians had used the milk station to make bottled milk into a form of civic property owned and managed by doctors, which they could allocate among patients in their discretion, balancing the fees charged. Because each blood sale was structured as an individual financial transaction between supplier and patient, there was no way to perform a similar balancing act in support of the goal of providing this life-saving treatment to all who needed it.

Doctors who considered it their professional duty to provide medical care regardless of the ability of patients to pay did their best to combat this problem. One solution was a registry of unpaid suppliers. In some towns, civic organizations created such registries: lists of citizens prosperous enough to pay professional donors for themselves but willing to donate occasionally for the indigent.¹²⁷ In large urban public hospitals, where no patient could afford professional donor fees and the blood supply problem was a daily crisis, doctors adopted a different approach. They created an institution that was like the

122. SWANSON, *supra* note 4, at 40-41.

123. Herbert Z. Giffin & Samuel F. Haines, *A Review of a Group of Professional Donors*, 81 JAMA 532, 532 (1923).

124. Philip Levine & Eugene M. Katzin, *A Survey of Blood Transfusion in America*, 110 JAMA 1243, 1245 (1938).

125. Thomas Hale Ham, *Transfusion Therapy: A Review of Blood Groups, Transfusion Accidents, Hemolytic Reactions, Stored Blood, Transfusion Methods, and Plasma and Serum Transfusions*, 223 NEW ENG. J. MED. 332, 332 (1940); Reuben Ottenberg, *Reminiscences of the History of Blood Transfusion*, 4 J. MOUNT SINAI HOSP. N.Y. 264, 270 (1937).

126. L.W. Diggs & Alice Jean Keith, *Problems in Blood Banking*, 9 AM. J. CLINICAL PATHOLOGY 591, 591 (1939); Levine & Katzin, *supra* note 124, at 1245.

127. Arthur John Collinson, *The Legion of Blood Donors!*, HYGEIA 236, 236-37 (1940); William DeKleine, *Red Cross Blood Transfusion Projects*, 111 JAMA 2101 (1938); C.A. Pons, *The Blood Donor Registry as a Substitute for the Blood Bank*, 9 AM. J. CLINICAL PATHOLOGY 587, 589-90 (1939); J.C. Furnas, *Blood from a Stranger*, SATURDAY EVENING POST, Aug. 20, 1938, at 8.

milk station in that it collected and maintained a body product inventory under medical control and enabled doctors to access the product whenever they felt it was necessary, without having to search for volunteers or inquire into the finances of their patient. This institution, which became known as the “blood bank,” allowed doctors to treat disembodied blood as civic property-in-action, exchanged in service of a medical vision of the public good.

D. Body Product Banks

Both the term “blood bank” and the new civic conception of blood as property-in-action were the innovations of Dr. Bernard Fantus, a pathologist at Cook County Hospital in Chicago, Illinois. In 1937, he adopted the metaphor of a financial bank to describe his blood supply management system, which was designed to eliminate reliance on professional blood donors and thus save the lives of poor patients who could not afford to buy blood.¹²⁸ In reimagining the way blood and money flowed from suppliers to recipients, Fantus expanded his vision of the good to be served by such exchanges from the initial focus on a safe and adequate supply to a broader vision that also encompassed the medical ideal of providing care to all who needed it. While neither Fantus nor his medical colleagues explained it in such terms, the blood bank transformed blood from market property-in-action to civic property-in-action.

In the depths of the Great Depression, Cook County Hospital, funded by the county to provide care for the indigent, was suffering extreme budgetary constraints.¹²⁹ At Cook County, as at other public hospitals, some patients died for want of blood.¹³⁰ Seeking to remedy this situation, Fantus created an institution, formally known as the Blood Preservation Laboratory,¹³¹ which would make disembodied blood into property-in-action. Fantus replaced individual transactions between professional donors and patients with a communal system of blood as a shared resource under medical control. While his plan depended on the use of stored blood rather than blood freshly collected at the bedside,¹³² his key innovation was conceptual, a

128. *The Therapy of the Cook County Hospital*, 109 JAMA 128, 128 (Bernard Fantus ed., 1937); see also LEDERER, *supra* note 4, at 89; SWANSON, *supra* note 4, at 49-51, 56-59.

129. SWANSON, *supra* note 4, at 49.

130. Bernard Fantus, *Cook County's Blood Bank*, 50 MOD. HOSP. 57, 57 (1938).

131. *Id.*; Karl A. Meyer, *The History of the Cook County Hospital Blood Bank*, 23 Q. BULL. NW. U. MED. SCHOOL 318, 319-20 (1949); Elizabeth H. Schirmer, *The County Blood Bank*, COUNTY INTERN 5 (1943).

132. While Fantus worked to test and improve technologies of storing blood, those technologies had been developed over time by many previous researchers. SWANSON, *supra* note 4, at 52-55. Work on preserving blood began before World War I and was used to provide blood for military use during that conflict. William H. Schneider, *Blood Transfusion in Peace and War, 1900-1918*, 10 SOC. HIST. MED. 105, 117-18 (1997). In the peacetime Unit-

method of accounting for pints received and pints used. To explain the management of his new laboratory, Fantus borrowed a term associated with capitalism and markets, the “bank.” Doctors were to treat the hospital’s blood inventory like flows of money in and out of a financial bank. “Just as one cannot draw money from a bank unless one has deposited some,” so too the Cook County blood bank “cannot supply blood unless as much comes in as goes out.”¹³³ The blood “bank” treated pints of blood as abstract units of value, just as a financial bank transforms each dollar bill into an abstract concept existing as credits and debits, which link the physical material deposited with that withdrawn. Through the bank, the act of supplying blood became the transfer of a fungible commodity in which the supplier was no longer giving or selling blood to a particular patient, but simply providing a unit of value without knowing the identity of the recipient. In this way, the blood bank increased the commodification of blood. Like the pediatricians who created mothers’ milk stations, however, Fantus was not interested in organizing a free market in a body product or in making a profit. His vision of the new relationship between blood and money was driven by his medicalized conception of the public good in which all who needed blood could receive it.

Like a milk station, a blood “bank” could be stocked by purchasing blood and then reselling it on a sliding fee scale.¹³⁴ This approach was not possible at Cook County Hospital, however. Because all the patients were indigent, there was no possibility of using the better-off to subsidize the poor. But Fantus had an advantage over milk station administrators. Unlike human milk, which could never be supplied by

ed States, the Mayo Clinic may have had the first standing inventory of stored blood for emergency use. See J.S. Lundy, R.M. Tovell & E.B. Tuohy, *Annual Report for 1935 of the Section on Anesthesia: Including Data on Blood Transfusion*, 11 PROC. STAFF MEETINGS MAYO CLINIC 432 (1936) (copy in NHU-0677: Subject Files, Blood Bank Folder, Mayo Clinic Historical Unit, Rochester, MN). One early center of research on blood preservation was Columbia-Presbyterian Hospital in New York City, where the ongoing work by Dr. John Scudder was aided by the efforts of graduate student Dr. Charles Drew in the 1930s. By the time Drew published his dissertation on banked blood in 1938, he was a leading expert on blood storage and blood banking. Charles Richard Drew, “Banked Blood”: A Study in Blood Preservation (1938) (unpublished D.M.S. dissertation, Columbia University), <https://profiles.nlm.nih.gov/ps/access/BGBBJT.pdf> [<https://perma.cc/RF6G-FREQ>]; see also William H. Schneider, *Blood Transfusion Between the Wars*, 58 J. HIST. MED. 187, 192-93 (2003) (innovations that led to use of stored blood by mid-1930s). Drew’s early leadership in the World War II national blood program and his willingness as an African American to speak out against racial segregation of blood led to an oft-repeated mistaken belief that Drew single-handedly created the blood bank. SPENCIE LOVE, ONE BLOOD: THE DEATH AND RESURRECTION OF CHARLES R. DREW 197-99 (1996).

133. Bernard Fantus, “Therapy of the Cook County Hospital,” *Bulletin C* (May 1937): 1, copy in Box 1 2002-199, Bernard Fantus Papers, University of Chicago Archives, Chicago, Illinois and reprinted in revised form as *The Therapy of the Cook County Hospital*, *supra* note 128, at 128.

134. Fantus suggested that private hospitals might use such a scheme to manage their blood supplies. Fantus, *supra* note 130, at 58.

recipient babies, almost everyone who needed blood could supply blood. By separating the time of supply from the time of use, patients themselves could supply blood after recovery. Friends and family could supply blood more easily if the person supplying on behalf of a patient was not required to have the same blood type as the patient. The poor might lack cash, but they had blood. Fantus created an institution that relied on the obligation of all who used blood to provide blood.

His new bank required physicians to get their patients who needed blood to recruit anyone available to give a unit of blood. There was no need to search for a volunteer who matched the patient's blood type or who was available to come to the hospital at the time of transfusion. A pint of any blood type, given at any time, was deposited in Fantus' refrigerator and became a "credit." Doctors at Cook County could withdraw blood from the hospital supply as needed so long as their withdrawals (their "debits") did not exceed their credits.¹³⁵ The blood bank administrators maintained accounts, striving to keep the books balanced.

Fantus' innovation was wildly successful. While most doctors preferred fresh blood to stored blood for transfusions, doctors around the country had been disturbed by their inability to transfuse indigent patients. They shared Fantus' goal of allowing doctors, rather than the market for professional donors, to determine which patients received blood. Once publicized in the medical literature, the "bank" as a system of managing a blood inventory was rapidly adopted by hospitals around the country.¹³⁶ Through the bank, doctors treated blood as civic property-in-action, serving the end of transfusing patients regardless of their ability to pay. Blood banks at Cook County and elsewhere found that they still needed to buy some blood to maintain adequate stocks, but such sales were no longer supplier to patient; instead, the sales were supplier to bank, incorporated within the medical vision of ensuring blood was available for all who needed it.¹³⁷

While the two goals of a safe and adequate supply and allocation based on need drove doctors as they developed ways of exchanging both blood and milk, the physiological differences between blood and milk as body products led to differences in the treatment of suppliers. As described above, doctors saw mothers selling milk as a vulnerable population who needed medical attention and could benefit both from compensation and from the other benefits milk stations offered. The "double charity" model was stressed less in blood sales. As doctors sought reliable suppliers of blood for transfusion, however, they did consider the health of suppliers, both to protect the intended recipi-

135. *Id.* at 57.

136. LEDERER, *supra* note 4, at 55-58; SWANSON, *supra* note 4, at 60.

137. SWANSON, *supra* note 4, at 59.

ents from diseased blood and to fulfill their professional obligation to do no harm to suppliers. The donor registries provided regular suppliers with medical check-ups that were important not only in maintaining a safe supply, but also could serve to protect the health of sellers. The registries also kept records of each bleeding, established limits on how often their participants could sell blood, and how much blood a standard sale should entail.¹³⁸ The medical press paid at least lip service to the notion that “professional donors,” who were almost universally male, were “m[e]n of business” who were putting bread and butter on the family table, selling blood as an honorable way of earning during the high unemployment of the Great Depression.¹³⁹ The implication was that the blood line was better than the bread line and that payment aided these men and their families.

With the advent of the “bank,” however, and the new emphasis on the recipient population as the source of supply, this consideration of blood sales as beneficial to the supplier faded. The typical supplier became either a replacement donor (a patient, or a patient’s friend or family member), or a person who feared becoming a patient and purchased a blood assurance plan, in which donation of a pint allowed free blood for a year.¹⁴⁰ These suppliers received neither money nor free medical care. The benefit to these suppliers was instead in the return to health of the recipient, either themselves or a loved one, and their blood itself was payment for medical treatment. Blood selling still occurred, but the valorization of the seller disappeared, replaced by an emphasis on the responsibility of patients to repay blood “loans.”¹⁴¹

Ironically, the analogy between body products and money created by the “bank,” while developed to promote blood as civic property-in-action, later came to encourage a market property view of body product exchange, as the term “bank” became applied to all body product inventories. During the Cold War era, as body products (particularly banked blood) became a more common part of medical care and became property-at-law, they became increasingly viewed as market rather than civic property. In this changing environment, doctors, patients, and suppliers began to focus for the first time on the significance of the gift/commodity dichotomy and to assume the associated moral hierarchy of the standard narrative.

138. See *supra* text accompanying note 40 (New York City enforced these requirements by municipal regulation.); see also SWANSON, *supra* note 4, at 46-47.

139. SWANSON, *supra* note 4, at 42-44. For the gendered aspects that distinguished the treatment of milk-selling mothers from “men of business,” see *Id.* at 234-35.

140. *Id.* at 56-57, 108-09.

141. *Id.* at 113.

V. ORIGINS OF THE GIFT/COMMODITY DICHOTOMY

The early history of body products demonstrates that doctors created and treated disembodied blood and milk, the first body products, as civic property-in-action by using market exchanges to further a medical vision of the public good. By 1984, however, as the passage of NOTA evidences, the gift/commodity dichotomy and the standard narrative had become underlying assumptions of law and policy discussions. These discussions focused on supplier payment as the key question in managing body product supply and allocation. The turn to a market property perspective on body products, the increasing importance of the gift/commodity dichotomy, and the association of a moral hierarchy with gifts and sales were interrelated changes arising out of a complex series of dynamics in American medicine, law, and society during the early Cold War decades. To denaturalize these assumptions, we need to identify the powerful factors that created the dichotomy and its explanatory narrative and that have contributed to the strength and endurance of these assumptions. These factors originated in the management of what had become the most ubiquitous body product by the end of World War II: blood. Surprisingly, the shift in understanding blood as a body product was not driven by concerns about supplier exploitation or the morality of asking people to sell parts of themselves. Rather, the motivations included the opposition of the medical profession to single-payer healthcare, the developing doctrine of strict product liability, opposition to for-profit blood banks, and a combination of entrenched racism and increasing understanding of blood-borne disease.¹⁴²

A. *Free v. Paid Blood*

During the 1950s and 1960s, blood banks became ubiquitous in American hospitals. At the same time, the “battle of the blood banks” raged.¹⁴³ The fight was not about the paid blood supplier. Like Fantus, doctors during this period had no moral or ethical objection to paying blood suppliers, but rather to their inability to treat indigent patients. This fight was thus about the obligation of recipients. Doctors and blood bankers objected to “something for nothing” blood; the idea that patients might not have to pay in money or in blood for a transfusion. The battle was fought between blood banks, particularly free-standing community blood banks often organized by county medical societies, and the American National Red Cross, which had opened regional blood collection centers after its success in recruiting blood donors for

142. For a more detailed discussion of this history, from which this synopsis draws, see *Id.* at 84-158.

143. M.G. Evans, *The Battle of the Blood Banks*, 56 *MED. ECON.* 55 (Feb. 1949).

the military during World War II.¹⁴⁴ Through this battle, the rhetoric and practice of blood supply management began to change, beginning the separation between gifted blood and sold blood.

The community blood banks and the Red Cross blood centers shared the goal of collecting blood to supply inventory to hospital banks. The blood bankers, organized into the American Association of Blood Banks (AABB),¹⁴⁵ emphasized the analogy between blood “banks” and financial institutions and stressed the obligation of each recipient to repay what they called blood “loans.” Every pint withdrawn required a pint deposited, and it was the “personal responsibility” of the patient-debtor to make that deposit. Patients unable to provide the blood themselves were encouraged to solicit friends and family to give to their account, and pay down their debt. Extra encouragement was provided in the form of “replacement fees,” per-pint charges that the bank would forgive once sufficient payment in kind was received.¹⁴⁶ The system was designed to maintain inventory. If the patient did not or could not repay in kind, the collected fees could be used by the bank to buy blood from a paid supplier.¹⁴⁷

The Red Cross rejected Fantus’ banking metaphor and offered a different model of blood supply management. It collected blood solely from unpaid suppliers and provided it to hospitals with the promise that patients would not be charged.¹⁴⁸ Rather than considering each patient a debtor, the Red Cross promised “free blood” to all who needed it. Members of the general public were the suppliers, solicited not as debtors but as civic-minded altruistic donors.¹⁴⁹ To the medical profession, which had been engaged in the buying and selling of body products for decades, the Red Cross promise of “free blood” without any obligation of recipient repayment was a dangerous severing of the relationship between body products and markets that posed a threat far beyond that of blood bank inventory shortages.¹⁵⁰

144. SWANSON, *supra* note 4, at 86, 88-90, 108.

145. Founded in 1947, the Association formally changed its name in 2005 to “AABB.” *AABB Name Change*, AABB HOME, <http://www.aabb.org/about/who/Pages/namechange.aspx> [<https://perma.cc/RJ8P-JKVK>].

146. SWANSON, *supra* note 4, at 97, 107-09. Note that balancing the blood accounts was made more complicated because some deposited pints had to be discarded due to contamination or age. To keep inventory up, many blood banks asked patients to repay loans at the rate of 3 or even 4 replacement pints for each pint withdrawn. *Id.* at 118-19.

147. *Id.* at 108. Community and hospital blood banks could also turn to for-profit commercial blood banks, the successors to the for-profit donor registries, to buy blood. These banks routinely paid all their suppliers. *Id.* at 131.

148. *Id.* at 91-92.

149. *Id.* at 91-93. During some periods, Red Cross centers and for-profit banks accepted blood from replacement donors as well, transferring a credit to pay off a patient’s debt to a hospital or community blood bank. *Id.* at 118-19.

150. *Id.* at 87, 94.

The perceived danger in removing the responsibility of the recipient to pay for blood, a system of so-called "paid blood," and replacing it with "free blood" for all, regardless of ability to pay, was in the similarity between this approach and a single-payer model of delivering health care. Government-funded health care provided without regard to ability to pay was another way of managing the long-standing tension between the professional ethic of providing care for all and the need to make a living as doctors. The traditional medical solution had been individual doctors dividing their time and resources as they saw fit between private paying patients and charity patients. Since the early twentieth century, the American Medical Association (AMA) had formally preferred this solution as more protective of medical autonomy and profits than government-funded healthcare. With the beginning of the sharp rise in healthcare costs in the post-war decades, stimulated by more effective and more expensive hospital-based care, the traditional solution was under threat because fewer patients could afford the costs of hospitalization. America's wartime allies, like Great Britain, bolstered national health plans, and in the 1960s, over the opposition of the AMA, the United States passed Medicare and Medicaid, ushering in a new era in healthcare financing for some sectors of the population.¹⁵¹

During these decades, the relationship between disembodied blood and the market became a proxy for these larger policy disputes. Fighting this battle, blood bankers and organized medicine embraced the banking metaphor with increasing fervor, insisting that "paid blood" was superior to free blood, as they focused on the exchange between patient and bank as the crucial characteristic of body product management. Free blood or paid blood was not simply a question about how to acquire and manage blood, but also a struggle between American democracy (assumed to be premised on liberal capitalism) and socialism/communism. One attendee at the founding meeting of the AABB warned his local medical society that "American free enterprise" was at risk if the "fundamental responsibility for replacement of blood bank loans" was not assumed by the borrower, that is, the patient.¹⁵² The next step after "free blood" would be a "police state" and "ultimately . . . a form of existence by directive."¹⁵³ Fighting this battle in the context of Cold War anti-communism and rising health care costs, blood bankers hardened Fantus' banking metaphor, emphasizing that banked blood was a "personal resource" rather than a communal one, shifting to a more market property

151. STARR, *supra* note 101, at 235-37, 280; SWANSON *supra* note 4, at 94-99.

152. Julius Winston Davenport, Jr., *Blood Bank Administration*, in PROCEEDINGS OF BLOOD BANK INSTITUTE 121, 124, 126 (1947).

153. Julius W. Davenport Jr., *Blood Transfusion in Louisiana: A Problem in Adequate Medical Care*, 102 NEW ORLEANS MED. & SURGICAL J. 259, 259, 263 (1949).

viewpoint in which individual preference satisfaction appeared to be the dominant goal.¹⁵⁴ Focusing on “individual responsibility,” transaction by transaction, the medical profession lost touch, at least rhetorically, with the intended civic property aspects of the banking metaphor. Through their focus on the obligation of patients to pay for blood, the “bank” became instead a powerful means of explaining blood as private market property, like money in the bank.

B. Product Liability and Blood Banking

The opposition between “free” and “paid” blood of the blood bank battles, while focused on exchange of a body product for value, differed from the contemporary gift/commodity dichotomy and had a different accompanying narrative. In this earlier narrative, it was recipient payment that was responsible, American, and virtuous, whereas receiving blood as a free gift was shiftless, communistic, and morally suspect. A further shift to the contemporary dichotomy occurred as banked blood as property-in-action became increasingly also considered as property-at-law.

Before the blood “bank,” there had been lawsuits claiming harm from blood transfusions.¹⁵⁵ But in ways unforeseen by Fantus, the enthusiastic medical embrace of the bank metaphor, and particularly the focus on recipient payment, caused lawyers and judges to think about the legal framework governing blood transfusion in new ways. To their horror, doctors and blood bankers found their actions in collecting, preparing, and using blood judged under product liability law. The legal system, accustomed to regulating businesses, consumers, and commerce, considered property exchanged in markets as market property, leaving no room for a civic property perspective.

Product liability law, a tort doctrine developed by courts at mid-century, emerged out of cases in which consumers were injured through use of an unsafe product but could not prove any negligence. Faced with a choice of innocent individuals bearing the costs of their injuries or imposing the obligation of compensation on manufacturers, courts developed a theory that all products came with an implied warranty of fitness for their intended purpose, which, if breached, entitled the injured consumer to compensation from the manufacturer.¹⁵⁶ In 1953, counsel for Mrs. Perlmutter, a New York woman who had allegedly contracted hepatitis from a blood transfusion, argued

154. American Association of Blood Banks, *Blood: A Personal Resource, A Position Paper* (Sept. 20, 1976), copy included in BERNICE HEMPHILL, *THE MOTHER OF BLOOD BANKING: IRWIN MEMORIAL BLOOD BANK AND THE AMERICAN ASSOCIATION OF BLOOD BANKS, 1944-1994*, interviewed by Germaine LaBerge 431 (1998).

155. SWANSON, *supra* note 4, at 123 (describing lawsuits in 1920s and 1930s).

156. G. EDWARD WHITE, *TORT LAW IN AMERICA: AN INTELLECTUAL HISTORY* 168-71 (2003).

that this doctrine should apply in her case. Perlmutter's attorney convinced a state court that her payment of \$60 for the infectious pint of blood constituted a sale of a defective product and that the hospital was liable for all her resulting harm without any proof of negligence.¹⁵⁷ Even though the New York appellate court later overturned the ruling in a 4-3 decision, both the lower court decision and the three-judge dissent disturbed doctors and blood bankers.¹⁵⁸

Neither the judges nor the medical professionals had any difficulty with the status of disembodied blood as property. In its decision, the appellate court readily agreed that this body product was property-at-law, a conclusion that affirmed medical treatment of blood as property-in-action.¹⁵⁹ Nor were the parties or the court concerned about whether the blood had been bought from or donated by its *supplier*. The legal issue in 1953 was the interpretation of the bill sent to the patient, representing the insistence of the supplying blood bank that all blood should be "paid blood."

The four-judge appellate majority agreed that banked blood was property that had been sold by the bank and purchased by the patient. But the judges nevertheless refused to designate the transaction as a sale of a good:

Concepts of purchase and sale cannot separately be attached to the healing materials—such as medicines, drugs or, indeed, blood—supplied by the hospital for a price as part of the medical services it offers. That the property or title to certain items of medical material may be transferred, so to speak, from the hospital to the patient during the course of medical treatment does not serve to make each such transaction a sale.¹⁶⁰

Organized medicine agreed with the outcome, if not all aspects of the reasoning. Doctors and blood bankers considered themselves medical professionals providing health care services to patients, not manufacturers. Yet they also considered the transfer of blood as property-in-action as tantamount to a sale of a product. Medical professionals were convinced that the invisible hand of the market was the best motivation to keep Americans participating in the blood supply chain at the levels necessary to have adequate amounts, as well as a bulwark against socialized medicine. As one blood bank supporter reiterated in 1955: "[T]he hospital or community blood bank is based on the philosophy that blood is a biological *product*,

157. *Perlmutter v. Beth David Hosp.*, 128 N.Y.S.2d 176, 177 (N.Y. Sup. Ct. 1953), *aff'd without opinion*, 129 N.Y.S.2d 232 (N.Y. App. Div. 1954).

158. *Perlmutter v. Beth David Hosp.*, 123 N.E.2d 792, 798 (N.Y. 1954); SWANSON *supra* note 4, at 129.

159. *Perlmutter*, 123 N.E.2d at 794.

160. *Id.*

like penicillin or any other commodity, and as such should be handled on economic principles.”¹⁶¹ Blood banks, hospitals, and doctors wanted to be free to sell or give away body products, as products; however, they also understood these products as civic property-in-action, which they could use in their professional discretion without implicating the law of sales premised on market property-at-law.

Although the hospital blood bank ultimately convinced the New York court in *Perlmutter* that banked blood was a service rather than a good, legal threats continued in subsequent lawsuits and in the developing legal literature.¹⁶² Despite the eventual outcome in *Perlmutter*, the AMA advised rethinking the relationship between blood, cash, and markets, at least when billing patients. “Instead of making a charge for blood, the hospital should make an equivalent and specific charge for the use of its facilities [i.e., the hospital blood bank] and services of its [blood bank] technicians.”¹⁶³ The medical profession also sought legislative changes and succeeded in getting what became known as “blood shield” laws passed in most states, which declared that banked blood was not legally a product.¹⁶⁴ If considering blood as property-at-law meant it was market property, better that it not be property at all, at least legally. These changes in law and practice assisted the shift in focus away from recipient repayment, a focus that eventually moved toward supplier compensation in the gift/commodity dichotomy.

C. For-Profit Blood Banking

The transition in focus from recipients to suppliers was apparent in the arguments made by physicians, hospitals, and the administrators of a non-profit community blood bank in Kansas City in the 1960s during a Federal Trade Commission (FTC) investigation. In response to a complaint brought by two for-profit blood banks alleging that the refusal of local hospitals to do business with them was an illegal restraint of trade, the FTC agreed that blood banking was part of interstate commerce and that such a boycott was illegal under federal trade laws.¹⁶⁵ The legal battle raged until 1969, when a federal appellate court finally overturned the FTC decision.¹⁶⁶ Through the

161. Donald E. Brown, *Basic Problem in Blood Banks: Free or Pay*, 84 MOD. HOSP. 51, 55 (1955) (emphasis added).

162. SWANSON, *supra* note 4, at 130 (citing cases and law review articles).

163. *Blood Transfusions—Medicolegal Responsibilities*, 163 JAMA 283, 286 (1957).

164. Franklin, *supra* note 41, at 474-75 n.203 (laws passed in 41 states between 1955 and 1971); Kessel, *supra* note 41, at 277 n.51 (laws passed in Illinois and Florida).

165. *In re Cmty. Blood Bank of the Kan. City Area, Inc.*, 70 F.T.C. 728 (1966) (providing the facts and history of the dispute, as well as the FTC ruling).

166. *Cmty. Blood Bank of the Kan. City Area, Inc. v. Fed. Trade Comm'n*, 405 F.2d 1011, 1022 (8th Cir. 1969).

lens of the standard narrative, this dispute was a successful campaign by the medical profession to choose safe, donated blood from the non-profit community blood bank rather than unsafe, bought blood from for-profit blood banks in order to protect patients. Re-examined through the lens of property theory, however, the controversy is revealed as a fight between two conceptions of property. The FTC assumed a narrow, market property understanding when it investigated blood as property-in-action in Kansas City. In their inveigling against “bought blood,” the new pejorative that would come to replace “free blood” in the medical lexicon, the local doctors asserted a civic property view of blood against the profit-maximization of the for-profit banks. In their arguments, they revealed that their medical ideals of professionalism and service remained, despite the heated rhetoric of the blood battles.

The Kansas City dispute developed because the local medical society delayed opening a non-profit community blood bank due to internal disputes.¹⁶⁷ The hospital blood banks needed help maintaining inventory, and two for-profit blood banks opened to supply that need. Demand created an opportunity to make profits buying and reselling blood. The for-profit banks relied almost exclusively on payments to impoverished locals to acquire blood and were supervised by directors whose experience and knowledge of blood management techniques were minimal. Once the non-profit community blood bank opened, the doctors who practiced at the Kansas City hospitals greatly preferred blood provided from an organization they themselves controlled. The local doctors therefore agreed that no hospital would accept blood from the for-profit banks and that the hospital blood banks would not consider a donation at such banks as repayment of a blood loan.¹⁶⁸

During the course of the litigation, the boycotting doctors justified their actions in multiple ways. They pointed to the dubious credentials of the for-profit bank administrators and argued that blood from those banks posed a health risk. Some argued that “paying [donors] for blood [was] morally wrong.”¹⁶⁹ And they repeatedly asserted the position that had ultimately triumphed in *Perlmutter*: banking blood and providing blood to patients for transfusion was a service, not trade in goods, and therefore the FTC had no jurisdiction.¹⁷⁰ This last argument, used to translate medical civic property-in-action into legal non-property, obscured a fundamental aspect of the Kansas City

167. *In re Cmty. Blood Bank*, 70 F.T.C. at 915.

168. *Id.* at 739.

169. *Id.* at 819.

170. The banks eventually won on jurisdictional grounds, although not based on the good/services distinction. The Court of Appeals found that the FTC did not have jurisdiction over non-profit entities. *Cmty. Blood Bank*, 405 F.2d at 1022.

dispute.¹⁷¹ Whether banked blood was a good or service did not distinguish the for-profit banks the doctors opposed from the non-profit bank they supported. The for-profit banks and non-profit bank each supplied the hospital blood banks that ultimately responded to a doctor's orders and provided blood for transfusion as part of medical treatment. Nor, despite the testimony of some doctors, were the two sides in fact arguing about whether professional donors were moral or safe, because all the banks relied on paid suppliers. The non-profit bank favored by the doctors bought 17-40% of its blood during the period of the dispute and conducted blood drives in a state prison, recruiting suppliers that were equivalent in socioeconomic status to the impoverished blood sellers supplying the for-profit banks.¹⁷² While the objections to the lack of qualifications of the bank administrators were valid, elsewhere the blood bank community was addressing such concerns not by boycotts, but rather by creating its own certification standards to assure banks of the quality of blood received from other banks.¹⁷³

Although the parties did not articulate the dispute in these terms, the most significant difference between the for-profit banks and the non-profit bank was in the treatment of blood as property-in-action. The goal of the for-profit bank administrators was to make a profit by selling blood for more than they paid for it. They treated blood as market property, a commodity traded in markets for individual wealth maximization. Following the legal assumption that all property was market property, the FTC readily accepted their claims. The non-profit banks' refusal to deal was an illegal constraint on what was otherwise understood as a free market, an action that impermissibly deprived the for-profit banks of their profits, in violation of regulations designed to increase competition and keep prices low.

The non-profit community bank also understood blood as property-in-action but conceived of that property very differently. Its goal was to maintain a stock so that it could provide the blood needed by the local hospitals; ultimately, the local medical society that founded it wanted safe, typed blood available whenever a doctor chose to order it for any patient. It had been designed to serve the medical vision of blood as civic property. The difference between blood as market property and civic property drove the distaste of doctors for the for-profit

171. This position was formally adopted by the AABB in 1962. American Association of Blood Banks, *Statement of Principles of Blood Procurement* (Oct. 30, 1962), copy included in Addendum to Memorandum to Assembly Members on the Committee on Public Health, California State Legislature, dated March 25, 1966, California State Archives, A/C Public Health, AB 333, 1963.

172. *In re Cmty. Blood Bank*, 70 F.T.C. at 765, 876.

173. E.R. Jennings, *Standards, Inspection, Accreditation Programs of American Association of Blood Banks*, in PROCEEDINGS OF CONFERENCE ON BLOOD AND BLOOD BANKING 109-11 (1964).

banks and contributed to the operational differences they found objectionable. It was not the buying and selling of blood that disturbed them, but rather buying low and selling high, at whatever price the market would bear, without any thought of a “double charity” or of fair allocation of resources between rich and poor. Doctors in Kansas City and elsewhere had tolerated market property institutions as part of the blood supply chain when necessary and as part of a system of generating an inventory that they could control as civic property-in-action. Since the first for-profit blood registries, doctors had condoned some profit-making by middlemen, as well as by the suppliers themselves. With the primary goal always remaining an adequate supply, when doctors and hospital blood banks needed to rely on for-profit banks, they did so. The New York City blood supply, for example, was notoriously reliant on for-profit banks.¹⁷⁴ When there was an alternative, however, doctors and hospitals chose to work with institutions aligned with their medical vision for blood as a body product. The opening of the community blood bank in Kansas City provided that alternative, and the doctors shifted their demand accordingly.

During the blood bank battles, when the enemy was what the AMA called “socialized medicine,” the medical profession had elided the distinction between modes of propertization. Blood bankers had focused on the market nature of body products in order to emphasize the commitment to free market capitalism in healthcare. The FTC action, like the *Perlmutter* case, revealed the legal costs of the medical embrace of free market ideology. While doctors opposed “free blood,” they also were uncomfortable with the free hand of the market displacing their expertise in allocating medical care.

In response to these legal challenges, the medical profession began to turn away from *any* exchange of blood for cash. In addition to following the AMA recommendation to change billing practices to avoid the appearance of selling a product to patients, blood banks also began to rethink the payment of suppliers. Blood sales by suppliers were a classic market exchange of property, and invited application of commercial law principles. Further, they were a foundational aspect of the for-profit business model that made non-profit banks and doctors so uncomfortable in Kansas City. As part of an effort to avoid the construction of blood as market property by a legal system that largely recognized only one perspective on property and to distinguish preferred non-profit banks from for-profit banks, the professional donor, long a mainstay of the American blood supply, became newly suspect as a participant in a cash-for-blood exchange. This suspicion, and the focus on supplier payment as the crux of the

174. *Cash Blood Banks Thriving in City*, N.Y. TIMES, July 7, 1968; see also SWANSON, *supra* note 4, at 106.

gift/commodity dichotomy, was further fueled by fears of hepatitis and entrenched racism.

D. Racism, Disease, and Gifting Blood

As per-pint patient charges disappeared, the transaction between supplier and collecting institution remained the most visible part of the blood system to most Americans. The less visible reality was that all banked blood, regardless of its source, remained commodified property-in-action. Raw blood was processed into a fungible body product, which could be billed out to patients as “services,” traded between banks, or even sold to for-profit companies that used whole blood to make other blood products.¹⁷⁵ Its origins in an unpaid donation at a Red Cross center did not keep blood from being treated as a commodity; blood sourced from voluntary donors, as well as from replacement donors and paid donors, became a commodity. As suppliers, however, Americans experienced the difference between giving in their workplace at a blood drive, or at the hospital for a relative’s account, and selling their blood at a storefront location in a poor part of town.

The professional donor had experienced downward mobility with the increasing emphasis on replacement donors. While doctors were uncomfortable with the market property vision of for-profit banks that recruited the majority of paid blood sellers and with the legal implications of cash exchanges, the lay public’s opposition had different origins. Americans increasingly saw the paid seller not as the professional “man of business” he had been during the 1930s, but as dirty, desperate, potentially diseased, and often a member of a racial minority. This perception sometimes, but not always, matched reality. Blood sellers in the postwar decades included impecunious college students, the temporarily unemployed, and in rural areas of Minnesota within driving distance of the Mayo Clinic, church groups seeking to earn money for their religious communities. They also included skid row derelicts, especially in cities, and increasingly, it was these sellers who were discussed in negative tones in the popular press.¹⁷⁶ Patients had two mutually reinforcing reasons to shun the paid supplier: sociocultural anxiety about race and class, and a rising concern about transfusion-acquired hepatitis.

The adoption of the banking metaphor, with its assumption that all blood was equivalent, had never been strong enough to eliminate deep-rooted cultural beliefs pre-dating blood transfusion and blood banking that all blood was *not* the same. Blood, as the carrier of personal characteristics and family traits, was long believed to transfer

175. DOUGLAS STARR, *BLOOD: AN EPIC HISTORY OF MEDICINE AND COMMERCE* 250-52, 260-65 (1998) [hereinafter STARR, BLOOD].

176. SWANSON, *supra* note 4, at 143-44, 146-49.

such qualities to a vulnerable patient, just as a baby shared the blood of his or her family.¹⁷⁷ In this understanding of blood, receiving a transfusion from a social inferior was a threat. Fantus and many of the first blood bankers had segregated blood by race, assuming that white patients would object to blood from non-white donors, and this segregation had persisted throughout the World War II national blood program.¹⁷⁸

While fear of racial contamination through blood transfusion was considered unscientific by the 1960s, lingering prejudice against blood from racial others became reformulated into fear of “bad blood” from those who sold it, supporting what would become a standard narrative that donated, unpaid blood was superior.¹⁷⁹ While fears of blood-borne diseases were justified, discriminating against bought blood in favor of gifted blood could also act as a proxy for unexpressed discrimination on the basis of poverty and race. Given persistent popular beliefs about the sociocultural meaning of blood, it was easy to align safe blood with blood given from better-off replacement donors or voluntary Red Cross donors, and unsafe, diseased blood with blood sold by down-and-outers.

It was as formal racial segregation of banked blood was ending that a discussion in the medical literature about a possible correlation between “bought blood” and hepatitis spilled into the popular press. In the 1950s and 1960s, doctors and the lay public became increasingly aware of the risk of transmission of hepatitis via blood transfusion.¹⁸⁰ A Boston study published in 1959 that looked retrospectively at hepatitis cases in veterans’ hospitals between 1953 and 1957 showed a link between one for-profit blood bank and an increased incidence of transfusion-associated hepatitis in patients.¹⁸¹ But even as some correlation was shown, not all the evidence agreed. The same Boston study showed no correlation between blood ob-

177. LEDERER, *supra* note 4, at 109-12; SWANSON, *supra* note 4, at 140; TUCKER, *supra* note 25, at 117-18, 123-24.

178. See LEDERER, *supra* note 4, at 116-35; LOVE, *supra* note 132, at 141, 155-60, 194-97; SWANSON, *supra* note 4, at 64-65; Thomas A. Guglielmo, “Red Cross, Double Cross”: Race and America’s World War II-Era Blood Donor Service, 97 J. AM. HIST. 63 (2010); Phillip McGuire, *Judge Hastie, World War II, and the Army’s Fear of Black Blood*, 1 REV. AFROAM. ISSUES & CULT. 134 (1979); Phillip McGuire, *Judge William Henry Hastie and Military Hemophobia, 1940-1943*, 4 J. AFRO-AM. HIST. & GENEALOGICAL SOC’Y 127-35 (1983). Note that in parts of the United States, the civilian blood supply was never segregated; practices varied regionally.

179. LEDERER, *supra* note 4, at 123-29; Michael G. Kenny, *A Question of Blood, Race, and Politics*, 61 J. HIST. MED. & ALLIED SCI. 456 (2006). The reformulation is discussed in SWANSON, *supra* note 4, at 140-43.

180. SWANSON, *supra* note 4, at 145-46.

181. Calvin M. Kunin, *Serum Hepatitis from Whole Blood: Incidence and Relation to Source of Blood*, 237 AM. J. MED. SCI. 293 (1959).

tained from two other for-profit banks and hepatitis.¹⁸² In an era before any test for hepatitis, the best way to know if an asymptomatic supplier would transmit hepatitis was whether his or her blood had transmitted it before. Professional donors, as repeat suppliers, could therefore be considered “clean” donors, tested in the most reliable way possible—after their first donation, that is. Still, better-off Americans preferred to receive a “premium vintage” when they needed a blood transfusion, leading to organizations such as a suburban Chicago blood co-op, where white matrons and businessmen gave blood in exchange for free blood if needed, allowing them to avoid the potentially contaminated blood from the inner city where blood sellers were recruited from within the African American community.¹⁸³

By the 1960s, American doctors and the lay public were rethinking the relationship between blood as a body product and the market and coming to divide blood according to what would become known as the gift/commodity dichotomy. The focus on “free blood” versus “paid blood” of the blood bank battles, in which the role of the market in managing blood supplies was emphasized as a virtue, was being exchanged for a focus on gifted versus “bought blood,” in which treating blood like cash was a vice. The key transaction that separated good blood from bad, pure from impure, was the transaction with the supplier. The moral valence of buying blood, a way of maintaining blood supplies used by almost all blood banks some of the time, was changing.

From the perspective of property theory, the concept of body products as civic property-in-action had become nearly lost. Assuming that all property must be market property, but rejecting market property as the appropriate category in order to avoid legal consequences, doctors and lawmakers alike considered the options of market-inalienability (getting rid of paid suppliers) and non-property (the blood shield laws) as the best ways of managing the relationship between body products and markets.

It was in this context that British sociologist Richard Titmuss published *The Gift Relationship: From Human Blood to Social Policy* in 1971.¹⁸⁴ Titmuss offered a framework for understanding and critiquing the American blood supply that proved broadly engaging.¹⁸⁵ His analysis, firmly rooted in a market property perspective, articulated the gift/commodity dichotomy and the standard narrative in

182. *Id.* at 298.

183. *Aurora Blood Co-op Stocks Premium Vintage*, CHI. TRIB., Oct. 5, 1969, at W9.

184. TITMUSS, *supra* note 15 (first publication in UK, 1970; in US, 1971).

185. See, e.g., Nathan Glazer, *Blood*, 24 PUB. INT. 86 (1971); Clark C. Havighurst, *Trafficking in Human Blood: Titmuss (1970) and Products Liability*, 72 LAW & CONTEMP. PROBS. 1-2 n.2, 2 n.5 (2009) [hereinafter Havighurst, *Trafficking*]; Paul A. Samuelson, *Blood*, NEWSWEEK, Sept. 13, 1971, at 94; *Seven Books of Special Significance Published in 1971*, N. Y. TIMES, Dec. 5, 1971.

popularly accessible language. He placed gifts in opposition to commodities, describing a divide that separated not only safe blood from unsafe blood, but also adequate supplies from scarcity and a nation bound together through civic altruism from a society corroded by the invasion of the market into personal relationships. Titmuss emphasized the corruptive harms of blood sales, arguing that blood sales, by reducing body products to dollars and cents, diminished altruistic gifting, which harmed both personhood and social bonds.¹⁸⁶ His critique offered both an explanation for American concerns about the adequacy and safety of the blood supply (reliance on paid suppliers) and a policy recommendation (switch to an all-donor supply). His book helped cement the focus on supplier payment in the law, policy, and practice of body product exchange.

The medical professionals who oversaw blood banks moved quickly via self-regulation to respond to public fears surrounding “bad blood” and to undercut Titmuss’ criticism. Without any legal ban, the professional whole blood donor virtually vanished. While banks continued to purchase some extremely rare blood types, less than three percent of whole blood came from paid suppliers by 1976.¹⁸⁷ By the late 1970s, blood was no longer a “personal resource,” but a “gift of life,” firmly placed on the morally correct side of the gift/commodity divide.

The gift/commodity dichotomy and the explanatory moral hierarchy based on supplier compensation were also adopted as the framework for analyzing other body product exchange. The dichotomy, with its assumption of market property and emphasis on market-inalienability as the preferred policy, was quickly applied to milk as the long tradition of buying and selling human milk was replaced by a gift model. By the 1970s and 1980s, the milk supplier as the recipient of “double charity” in the form of cash and other compensation was shunned, as bottled milk too became a precious gift, the “milk of human kindness,” for which milk bankers neither paid nor charged.¹⁸⁸ Nursing mothers who supplied milk were paid, not in cash, but in the “satisfaction of helping give other babies a chance for a better life, perhaps even a chance for life itself.”¹⁸⁹ Despite the past history of mothers’ milk stations as institutions deliberately organized to enhance the health of suppliers via payment, the newly-founded Human Milk Banking Association of North America argued that paying women for their milk threatened the health of the sup-

186. TITMUSS, *supra* note 15, at 263-64.

187. *Id.* at 124; *Oversight on Implementation of National Blood Policy, 1979*, Hearing before the Subcomm. on Health and Scientific Research, Committee on Labor and Human Resources, 96th Cong., 2 (June 7, 1979).

188. SWANSON, *supra* note 4, at 168, 177, 187-88.

189. *Donors Needed*, CHI. TRIB., Feb. 10, 1973, at 11.

plier, her baby, and recipients.¹⁹⁰ Although there is no federal law banning sales of breast milk in the twenty-first century, both non-profit and for-profit milk banks mimicked blood banks and relied on unpaid donation until the opening of Mother's Milk Cooperative.¹⁹¹

As described in Part II, the dominance of the dichotomy in legal and medical thought by the 1980s caused the development of human organs as body products to follow a different path than had blood and milk decades earlier. When Dr. H. Barry Jacobs publicized plans to create an organ brokerage that, similar to the first milk stations and blood banks, would rely on cash to suppliers to obtain organs as property-in-action that could then be allocated in the discretion of the owning doctor, Congress moved rapidly to pass NOTA.¹⁹² By the early 1980s, such marketization was not seen as a way of promoting access to treatment through the expert and beneficent hand of the doctor, as it had been under a civic property perspective, but rather as commodification into market property that threatened a range of free market horrors, from the poor selling themselves to the rich, to a society in which civic altruism of all sorts was reduced as citizens refused to act for the benefit of others without payment. With body products understood as market property, in action and at law, as new body products such as bone marrow, faces, and eggs have been developed through further medical experimentation, each such product has been created and exchanged, and its use debated, from within the framework of the gift/commodity dichotomy.

VI. BEFORE AND AFTER THE DICHOTOMY

The history of body products as property-in-action and later as property-at-law simultaneously denaturalizes the gift/commodity dichotomy in its contemporary form and suggests alternatives. Since the late twentieth century, the focus of the law and policy of body products has been supplier compensation, aimed at separating suspect market commodities from altruistic beneficent gifts. But history shows that this now-standard narrative supplanted an earlier narrative explaining the dichotomy as between suspect socialist gifts and democratic capitalist commodities, with recipient payment as the key feature. Further, both these narratives arose out of the adoption of the "bank" metaphor, created in a context in which the gift versus sale dichotomy did not exist at all, but instead, all the focus was on allocation based on need rather than on ability to pay.

190. Arnold & Lockhart Borman, *supra* note 54, at 143-44.

191. SWANSON, *supra* note 4, at 193-95.

192. LEDERER, *supra* note 4, at 98-99; Gross, *supra* note 27, at 178-88; Note, *Regulating the Sale of Human Organs*, 71 VA. L. REV. 1015, 1021-22 (1985). Many states have enacted their own versions of NOTA as well. Rao, *supra* note 12, at 376 n.58.

The practices of the medical profession during the first half of the twentieth century demonstrate that doctors understood market exchanges of body products as means, not ends, and initially did not attach moral weight to the distinction between gift or sale, free or paid. They did not understand marketization of body products as necessarily antithetical to concern with the flourishing of either suppliers or recipients, such that market inalienability needed to be enforced by norm or by law.¹⁹³ Rather, to those doctors inclined to think broadly about their roles in improving the overall health of those with limited resources, marketization appeared to be a possible means of promoting such flourishing. In their understanding, the propertization of disembodied body materials and their transfer for cash could promote three professional aims that they believed advanced the public good: first, maintaining a safe and adequate supply of body products that they could use to care for patients; second, using their expertise to pick candidates for treatment rather than allowing the market to decide who received treatment; and third, when possible, considering how healthy suppliers of body products might not only be induced to provide needed therapeutics, but also how the suppliers might be included as beneficiaries of the medical expertise of the doctors who bought their body products. By an analysis focused on propertization rather than marketization, this early understanding of body products as property-in-action is revealed as a medical version of the civic property tradition, in contrast to the narrower understanding of property as market property, triumphant in law and property theory by the 1970s.

Both property theory and the possibilities of body product exchange have developed since the pre-World War II era when human milk and blood was first bought and sold as medical property-in-action. As Alexander has demonstrated, the civic property tradition has persisted, but it has also changed since its eighteenth-century dominance when it was linked to visions of a republic anchored by land ownership.¹⁹⁴ Alexander and numerous others have worked in the last several decades to consider alternatives to market property for the twenty-first century. This progressive property movement can be understood as a descendant of civic property or property-as-propriety, revamped to reflect over two centuries of legal and social change and seeking to develop an overarching vision of its normative

193. While necessarily based on different evidence and a historical record that makes the viewpoints of the medical profession more accessible than those of suppliers and patients, this investigation thus reinforces recent sociological research demonstrating that turn-of-the-twenty-first-century participants in body product exchange fail to perceive their actions in selling and gifting as two mutually exclusive categories, ALMELING, *supra* note 13, at 127-33, and base their perceptions on a complex of institutional practices that vary among procurement organizations, HEALY, *supra* note 13, at 113.

194. ALEXANDER, *COMMODITY AND PROPRIETY*, *supra* note 16, at 4-5.

conception of the public good, based, for example, in democracy, pluralism, and social obligation.¹⁹⁵ Understanding the standard narrative as a historical artifact, rather than a universal truth, we can relinquish the body product exceptionalism which has been fostered by the gift/commodity dichotomy and bring body products into this creative conversation about the purposes of property by considering them both as property and as market commodities. Without turning back the clock, it is possible to draw upon history to think beyond the dichotomy and standard narrative about the law and policy of body product exchange in order to address current injustices. While leaving the development of a full theory of body property for further work, this Part identifies the possibilities of such theorizing created by recognizing historical facts on the ground and remembering medical visions of the purposes of this new property.¹⁹⁶

A. *Recognizing Historical Facts on the Ground*

The creation and use of body products as property-in-action in the first decades of the twentieth century drew upon two assumptions: that body products were property and that, as property, they could be traded in markets in which suppliers were compensated, at least in some circumstances. Through the actions of participants in body product creation and exchange, these assumptions were not just hypothetical; they were facts on the ground. In the decades since the entrenchment of the gift/commodity dichotomy, these assumptions have been contentious on both philosophical and pragmatic grounds.¹⁹⁷ Without reiterating these past debates, it is valuable to note the insights these historical facts on the ground bring to these discussions by allowing us to analyze body products as property and to reexamine our moral intuitions about bodies and markets while also remaining mindful of past failures.

1. *Remembering Body Products as Property-in-Action*

Despite the reluctance of courts in the late twentieth and early twenty-first centuries to recognize property rights in bodies and body products, body products have been property-in-action in the hands of doctors, suppliers, and patients since their creation as medical therapeutics. Further, body products as property-in-action are not merely

195. Rosser, *supra* note 17, at 108-111; *id.* at 110 (describing the “overlapping but not identical alternative visions” within progressive property).

196. For a recent approach to theorizing bodies (including body products) as property, see Render, *supra* note 14.

197. See *supra* Parts II and III; see also Stephen R. Munzer, *An Uneasy Case Against Property Rights in Body Parts*, 11 SOC. PHIL. & POL’Y 259 (1994); Munzer, *Special Case*, *supra* note 21; Rao, *supra* note 12, at 365-66 n.15, 453, 455 (literature review and her own argument).

a historical curiosity. In the absence of controlling law on the issue, Americans continue to treat disembodied body products as property, property they treat as belonging *ab initio* to its suppliers, who assume their right to sell or give it away, and then of the subsequent possessor, who has the right to use, resell, or donate such products. The assumption drives Internet-facilitated exchanges of body products, both sales and gifts. While Mother's Milk Cooperative, founded in 2013, has only recently begun to buy breast milk for processing and resale to the Medolac Corporation, manufacturer of shelf-stable breast milk, nursing mothers have been selling their breast milk directly to purchasers at whatever price the market will bear on the Internet for years.¹⁹⁸ Websites also facilitate what they call "milk sharing," uncompensated donation of milk.¹⁹⁹ While NOTA bans offering compensation for organs, the desperately ill and their families assume others can transfer possession of their kidneys and advertise for living donors.²⁰⁰ Websites designed to facilitate matching of those interested in donating kidneys with those seeking these body products, like those designed for milk sharing, allow suppliers and recipients to transfer ownership rights in disembodied body products, propertizing these body products even when money is not exchanged.

Thus, outside of the courtroom, Americans have been treating body products as property for more than one hundred years. As I argued in Part V, courts and legislators adopted the approach of denying property status to body products in order to protect them from the invisible hand of the market, based on the assumption that as property, they must be market property in its most restrictive sense.²⁰¹ A historical understanding of body products and their relationship to markets provides evidence to undercut that assumption and bolster arguments that market exchanges are not always harmful. Recognizing the gift/commodity dichotomy as a historical artifact and the standard narrative as a reaction to a particular political and social context that does not describe universal or inevitable qualities

198. Judy Dutton, *Liquid Gold: The Booming Market for Human Breast Milk*, WIRED (May 17, 2011, 10:05 PM), <http://www.onlythebreast.com/articles/liquid-gold-the-booming-market-for-human-breast-milk/> [<https://perma.cc/FR8U-8MVW>]; NCBA CLUSA, *Member News Service*, *supra* note 47; *Iowa Woman Takes Out Ad to Sell Her Breast Milk*, USA TODAY (Nov. 4, 2007, 8:22 PM), http://usatoday30.usatoday.com/news/offbeat/2007-11-04-breastmilk-sale_N.htm [<https://perma.cc/4KSX-E97T>].

199. *See, e.g.*, EATS ON FEETS, <http://www.eatsonfeets.org> [<https://perma.cc/M678-SR2B>]; HUMAN MILK 4 HUMAN BABIES, <http://www.hm4hb.net/> [<https://perma.cc/3V56-6LG5>]; *Breast-milk Donation*, MILKSHARE, <http://milkshare.birthingforlife.com/> [<https://perma.cc/25N5-L7TA>].

200. *See, e.g.*, *Living Donors Online!*, INT'L ASS'N OF LIVING ORGAN DONORS, INC., <http://www.livingdonorsonline.org/index.htm> [<https://perma.cc/8ZSA-CNXA>]; LIVING KIDNEY DONOR SEARCH, <http://www.livingkidneydonorsearch.com/how-to-be-listed-here/> [<https://perma.cc/9M9Z-DXJE>] (suggesting anyone needing a kidney should be on Facebook as a strategy for finding a donor).

201. *See, e.g.*, *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 488-89 (Cal. 1990).

of body products renders the need to craft a special set of non-property doctrines for body products less pressing. Rather than allowing a gap between the law and the practice of body product exchange to remain by keeping body products outside the law of property, we can instead consider how property-in-action can inform property-at-law. Body products need not remain an exception to discussions about the plural ends of property, both public and private.

2. *Reexamining Moral Intuitions*

To bring body property into these discussions, it is also necessary to face our “strong moral intuitions” against body product markets, acknowledging these views as historically created intuitions that have promoted body product exceptionalism. Given the layers of philosophical, religious, and pragmatic concerns that underlie those intuitions, as well as a current sociopolitical context that includes high income disparity, entrenched racism, and lack of consensus on healthcare financing, reconsidering those intuitions sufficiently to change the conversation about body product exchange is not a simple matter. Considering historical examples of body product markets can help by disrupting a blanket condemnation of all markets, in all products, in all circumstances, and thus opening the way for a more nuanced consideration.

For example, comparing the early mothers’ milk stations to current milk banks provides a forceful reminder that not all markets are the same and that it is possible to create a managed market in a renewable body product. As discussed in Part V, since its founding in 1986, the Human Milk Banking Association of North America has maintained the position that suppliers should not be paid.²⁰² Despite frequent shortages of banked milk, requiring the Association to develop guidelines for the ethical allocation of milk among needy babies, the Association “does not condone, and in fact, questions the practice of buying and selling human milk as a commodity.”²⁰³ The Association explains that offering money for milk would risk harm to suppliers’ infants because it would provide an incentive for a woman to sell milk needed by her own child and also harm recipients because suppliers would be motivated to adulterate milk to increase payments. Yet the Association explains its goals for its member institutions in much the same terms as Talbot and his colleagues did a century ago: the “collection and distribution” of milk “in a safe, ethical and cost effective manner.”²⁰⁴ The early doctors, however, did not perceive buying and selling milk as unethical and established institu-

202. HUMAN MILK BANKING ASS’N OF N. AM., *supra* note 54.

203. *Id.* at 1.

204. *Id.*

tions that used such cash exchanges as a means toward achieving their articulated goals of both providing milk to all babies who needed it and of improving the health of suppliers' infants, while also focusing on safety and cost-effectiveness.

As Alexander has repeatedly explained, taking a broad view of property allows rejection of a laissez faire market in a commodity without being anti-market or requiring complete market inalienability.²⁰⁵ Regulation of a body product market, like regulation of other markets, can be directed to ensure that "the market, to the extent that it is deemed to conflict with or to threaten the social good, be subordinated to the latter."²⁰⁶ Twenty-first-century unregulated sales of breast milk via the Internet can be considered a laissez faire market. While harms to sellers' children are as yet undocumented, there is evidence that this market offers risk to recipients due to high bacterial counts in milk purchased directly from suppliers, a risk milk banks minimize by discarding milk with bacterial counts over a certain threshold and by pasteurizing the milk.²⁰⁷ There is also evidence that such purchased breast milk is sometimes adulterated with cows' milk. When turn-of-the-twentieth-century physicians created managed markets, they used supplier payment to guard against the harms now identified by the Association. Payment not only helped keep supplies adequate and allowed doctors to ensure that the sellers had "good standards of living and relief from financial worry,"²⁰⁸ but also purchased compliance with surveillance of supplier and her baby. Medical examinations of seller and her baby, and the requirement that milk be expressed on site under the watchful eye of the station nurse, minimized the risks of a seller depriving her own baby, adulterating her milk, using unsanitary protocols, or hiding a dangerous medical condition. The Mother's Milk Cooperative offers another model by which a market in human milk could be managed; the Cooperative is an organization in which suppliers are also part-owners, which accordingly gives suppliers some stake in the market value, and hence the quality, of the milk the co-op sells.²⁰⁹

205. Gregory S. Alexander, *Property as Propriety*, 77 NEB. L. REV. 667, 669 (1998) [hereinafter Alexander, *Property as Propriety*].

206. *Id.*

207. Sarah A. Keim et al., *Microbial Contamination of Human Milk Purchased Via the Internet*, 132 PEDIATRICS 1227, 1227-34 (2013); see also Sarah A. Keim et al., *Cow's Milk Contamination of Human Milk Purchased Via the Internet*, 135 PEDIATRICS e1157, e1157-61 (2015).

208. Comm. on Mothers' Milk, *supra* note 118.

209. Note that the Co-op has only one buyer, a for-profit company that markets processed human milk to hospitals. Press Release, *Medolac Laboratories Announces the First Large Scale Purification of Human Milk Oligosaccharides (HMO)*, (Oct. 9, 2014), http://www.medolac.com/uploads/8/8/1/4/8814177/medolac_hmo_final.pdf [<https://perma.cc/9PZN-VXZB>]. A similar cooperative model, however, could be used to create an institution that, like HMBANA banks, supplies milk to multiple hospitals as well as to individual families.

Given the fall from grace of blood selling, it is useful to remember that cash payments for blood have also been used to increase the safety of the blood supply. As discussed in Part V, at mid-century, before there was a reliable test for hepatitis, paid suppliers, as repeat suppliers, could be the least risky sources of blood. The same correlation between paid suppliers and safer blood had occurred earlier. In the pre-World War II era, when blood-borne hepatitis was still unknown, one of the most dangerous known blood-borne diseases was syphilis. Although there was a blood test, doctors knew that it was possible for a recently-infected supplier to have undetectable levels in the blood, yet to transmit the disease to a recipient. The safest course was to conduct a genital examination, searching for signs of fresh infection. Registered professional donors were required to undergo such examination as part of their periodic medical examinations. When the Red Cross began to solicit the public at large for the wartime blood program, however, this type of examination was dropped, considered too insulting to the altruistic donors who were giving without compensation.²¹⁰ Measured by the risk of syphilis infection, then, gifted blood became less safe than bought blood.

The history of buying blood also demonstrates that money can be used to attract suppliers who are primarily motivated by altruism, not just those desperate for cash.²¹¹ The Mayo Clinic, faced with a growing need for blood in its hospitals, but located in the small city of Rochester, Minnesota, used replacement donors and unpaid donors, but also routinely paid suppliers in the post-war period. The Clinic blood bank developed a special category of church donors, groups who could be counted on to provide a known number of suppliers who drove in from a distance at set intervals to sell their blood. Eventually, the Clinic had a waiting list of churches wanting to get accepted into its program, by which congregants could raise money for their religious organization.²¹² Blood selling in this way became a “double charity,” with sellers benefitting both unknown patients and a non-profit community institution that was important to them.

In the twenty-first century, moremarrowdonors.org proposed a “double charity” model of supplier compensation to increase the number and genetic diversity of bone marrow suppliers, who join a registry of those willing to supply marrow in the future when their genetic profile is found to match that of a patient.²¹³ Moremarrowdonors.org wanted to offer a set amount of compensation to suppliers,

210. SWANSON, *supra* note 4, at 77.

211. For recent evidence of the possibility of cash compensation as a means of increasing the blood supply, see Nicola Lacetera et al., *Economic Rewards to Motivate Blood Donations*, 340 SCI. 927 (2013).

212. SWANSON, *supra* note 4, at 144.

213. *Flynn v. Holder*, 684 F.3d 852, 857-58 (9th Cir. 2012).

with payment received at the time of harvesting in the form of a rental subsidy, scholarship, or a donation to a charity of the supplier's choice. Troubled both by the scarcity of donors and the extra difficulty patients of non-European American ancestry have in finding a match, the organizers designed a managed market to increase the chance of matches for all patients in need. Knowing that race follows class in the United States, they deliberately sought to recruit suppliers from socioeconomic classes to whom rent subsidies or tuition money would be a charity, *i.e.*, needed and appreciated funds to improve the seller's quality of life. By including the option of compensating suppliers by a charitable donation, they also sought to recruit potential suppliers like the Minnesotan church groups, those who would be motivated to sell a body product in order to benefit one unknown individual and an organization important to them. While the Mayo Clinic was free to establish its church blood seller program in the 1950s, the managed market proposed by moremarrowdonors.org was opposed by the federal government as a violation of the ban on supplier compensation under NOTA. Despite limited success in the courts, moremarrowdonors.org has not yet implemented its plan.²¹⁴

3. *Proven Market Dangers*

Remembering past successful managed body product markets needs to be tempered with reminders of failure. In Kansas City in the 1960s, doctors were rightfully wary, not of blood sales so much as of for-profit blood banks. The low quality of the administration of those banks gave rise to legitimate concerns about the standards for supplier screening and blood processing, and thus about risks to recipients. There is ample evidence in the historical record that when institutions managing a body product market take a narrow view of a body product as a means of profit maximization, there are worrisome incentives to cut corners in ways that are risky to both suppliers and recipients. The market can “conflict with or . . . threaten the social good,” and individual actors, given the opportunity to make a profit, do not always subordinate their profit to the social good.²¹⁵

Some for-profit blood banks, like one bank identified in the Boston study, supplied blood much more likely to contain hepatitis because they recruited paid suppliers from populations with high rates of intravenous drug use, correlated with hepatitis infection. Other for-profit banks have relabeled blood to sell it past its expiration date.²¹⁶

214. See *id.* at 864-65; Press Release, Shaka Mitchell, *Government Set to Ration Life-saving Donations*, (Nov. 26, 2013), <http://moremarrowdonors.org/government-set-to-ration-life-saving-donations/> [<https://perma.cc/BL6Z-PHZ3>].

215. Alexander, *Property as Propriety*, *supra* note 205, at 669.

216. SWANSON, *supra* note 4, at 144-45.

Such prioritization of profit maximization could risk injury to suppliers as well as to recipients, as some early for-profit donor registries allegedly “bled [their registrants] white,” allowing too frequent donations in order to increase their commissions.²¹⁷

Yet it is not payment to suppliers that causes the medical risks, but rather the decisions of administrators. During the same period that several for-profit banks were found to be engaging in risky practices, the Salt River Blood Bank, a non-profit community blood bank supplying much of the southwest, found that it could more cheaply maintain an adequate supply by paying repeat suppliers to appear at regular intervals, rather than spending money recruiting less reliable unpaid suppliers. Using the same supplier screening and blood processing procedures as other AABB banks that preferred replacement donors, the Salt River Blood Bank had an equivalent blood safety record to banks that used few or no paid suppliers.²¹⁸

Administrator failures cannot always be avoided by regulation. In New York City, despite detailed municipal regulation of blood sellers early in the history of blood transfusion, fly-by-night donor registries with substandard treatment of suppliers were a problem before the transition to blood banks, and city hospitals continued to struggle with unusually severe problems with blood scarcity and safety through the postwar period.²¹⁹

This history, while not one of unqualified success, challenges our moral intuitions that body products need to be treated exceptionally in action and at law. These historical facts on the ground, that body products have long been property-in-action and property traded in markets, disprove the standard narrative. Like other forms of property, body products can be exchanged with and without compensation. They can be treated as market property in its narrowest sense, sold simply to make a profit, but they can also be treated by suppliers, recipients, and brokering institutions in broader terms. They can be exchanged directly or through for-profit or non-profit institutions. Exchanges can be unregulated, self-regulated, or formally regulated at the city, state, or federal level. Remembering the civic property tradition reminds us that what doctors once called “therapeutic merchandise” is not the only category of property recognized and exchanged to serve both private and public ends.²²⁰ There is no single narrative to explain all body property any more than there is a single narrative that can unify all property into a grand narrative. Recog-

217. SWANSON, *supra* note 4, at 45; Noah Fabricant & Leo M. Zimmerman, *The Cry for Blood*, 17 HYGEIA 881, 884 (1939).

218. SWANSON, *supra* note 4, at 113, 146-47.

219. *Id.* at 45, 106, 145.

220. James A. Tobey, *A New Foster-Mother*, 7 HYGEIA 1110, 1110 (1929).

nizing the pluralism of body products as property permits thinking beyond the dichotomy, combining historical facts with contemporary property theory to address the creation, allocation, and exchange of body products today.

B. Remembering Medical Visions

If we accept that body products are property and that they can be market-alienable property without necessarily being market property in its narrowest sense, the question then becomes how to incorporate body property within the law of property and markets. What purposes of property can be served by recognizing and regulating these forms of property? What is the appropriate role of law in limiting and facilitating the creation and allocation of body products? Both the historical record and the recent scholarly literature are rich with examples of ways to create and allocate such products.²²¹ The challenge remains, just as it was a century ago, to manage a particularly tricky supply chain dependent on human bodies in ways that promote the just and fair creation and allocation of these medical therapeutics.

History provides not only facts on the ground, but also an implicit theoretical framework as a way of evaluating propertization and marketization of body products. What I have called a medical version of the civic property perspective can be used to inspire our future thinking about body products, law, and markets to answer those questions. The civic property tradition allows us to consider body products as market-alienable property without abandoning them to the free market. In the classic version of that tradition from the earliest years of our republic, the challenge of such an approach is twofold: to formulate a normative vision of the public good that such property should promote and against which body product law may be measured, and then to craft laws to promote that vision. In the context of contemporary property theory, we might phrase the challenge as treating body products as property that can be exchanged in ways that “relate[] multiple public and private values . . . as coherent and mutually supportive.”²²²

The public good or public values that body property might promote can and should be considered from the perspective of property generally, as theorists have done since Radin’s earliest work on contested commodities. As discussed in Part III, my aim is to join the tradition of property and commodification theorists who have placed human

221. See *supra* note 48.

222. Alexander, *Property’s Ends*, *supra* note 16, at 1260. In the context of body property managed by institutional middlemen, such as “banks,” it is also particularly useful to consider the creation of institutions of property, and property as institutions. HANOCH DAGAN, *PROPERTY: VALUES AND INSTITUTIONS* xii-xiii, 3-75 (2011).

flourishing at the center of their analysis, while considering the joint private and public ends of property. But as we consider body products specifically, their history can provide useful, if insufficient, starting points for articulating particular ways that their propertization and marketization can promote human flourishing.

The doctors who first created body product supply chains did not discuss their practices in terms of property or law. Their guiding principles were more implicit than explicit and were drawn from medical professional ethics. Doctors first all wanted to save patients by using their expertise, and thus created these new therapeutics, which immediately required them to consider the problem of a safe and adequate supply. For some doctors, their ability to treat all patients in need was also a significant part of their professional identity and ethic, such that they sought to manage body product supplies to that goal. The necessity of managing human suppliers led some doctors, like Talbot and the blood bank administrators at the Mayo Clinic, to think in even broader terms about their ability to benefit suppliers as well as recipients, developing a “double charity” model of body product supply management. Based on these medical practices, I have identified historical interlocking goals for body product supply management that together suggest a starting point for thinking about the public ends of body products as private property: (i) to generate adequate and safe supplies of body products for use in medical treatment; (ii) to provide body products to all recipients who need them, not just those who can afford to pay; and (iii) to provide compensation to suppliers sufficient to encourage repeat donation, gain compliance with safety-related measures, and, in some instances, to promote the health and well-being of the suppliers themselves.

From these practices, we can articulate a generalized vision of the public good to be served by body product purchase and sale as *ensuring efficient access to safe body products by all who need them for medical care and promoting a society in which overall health and well-being is enhanced*. This vision combines a normative view of health care allocation (based on need rather than ability to pay) with a normative position that body supply management can be considered part of public health promotion, rather than solely a means of providing individual treatment.

Using this vision as the basis of the law and policy of body product management forces a shift in the perspective of regulation from the means of body product creation (sale or gift) to the ends of body products (patient treatment and public health). The difference can be seen by measuring existing laws and policies against this articulation. Today, almost no whole blood is purchased from suppliers in the United States. While black markets in organs exist, most transplants in the United States are performed using organs harvested from un-

compensated living or cadaveric donors. These policies were enacted to promote safety and a society in which overall health and well-being was enhanced by avoiding harms to sellers and recipients. As shown by the increasing scarcity of organs, however, NOTA has failed to achieve the goal of efficient access to body products for all who need them. Further, the self-imposed ban on paid blood suppliers in response to fears of hepatitis did not keep the blood supply safe when another undetectable transmissible disease was recognized: AIDS.²²³ In fact, the blood shield laws that declared banked blood non-property decreased legal incentives for blood bankers to guard against dangers in the blood supply, arguably slowing the adoption of steps to reduce the risk of transfusion-acquired AIDS.²²⁴ A regulatory focus on payment to sellers and a refusal to consider banked blood as a “good” has greatly limited supplier payment for blood and organs, at least within the United States. But it has failed to ensure a safe supply for all who need these therapeutics, the original goal of these policies. In contrast, the suggested “double charity” approach of supplier compensation by *moremarrowdonors.org* addresses safety and scarcity concerns in a manner that the organizers believe will promote the overall health and well-being in society by increasing fairness in access to donor marrow. The study they seek to carry out, to measure the effect of their proposed compensation scheme, offers the potential for data useful to craft regulation designed to “mutually support” public and private ends of body product marketization.²²⁵

If we, like the organizers of *moremarrowdonors.org*, reject the gift/commodity dichotomy, thinking about body products as property-in-action within the civic property tradition helps identify missed opportunities and new possibilities. For example, in Part IV, I explained how milk sellers in the 1930s and 1940s received not only cash payment, but also free medical examinations for themselves and their babies, supplemental nutrition in the form of cow’s milk, and training on infant care. The presence of the selling mothers in medically-run milk stations to express milk was seized as an opportunity to provide follow-up care to new mothers and infants, what later public health experts would call well-baby care. Doctors used these additional forms of compensation to help ensure that milk selling was not only non-health-threatening, but rather, health-promoting. Could a

223. See HEALY, *supra* note 13, 88, 92, 94-95, 101-06; SUSAN RESNIK, BLOOD SAGA: HEMOPHILIA, AIDS, AND THE SURVIVAL OF A COMMUNITY 113-36 (1999); STARR, BLOOD, *supra* note 175, at 266-98; Thomas H. Murray, *The Poisoned Gift: AIDS and Blood*, in A DISEASE OF SOCIETY: CULTURAL AND INSTITUTIONAL RESPONSES TO AIDS 205, 216-23 (Dorothy Nelkin et al. eds., 1991).

224. See Clark C. Havighurst, *Legal Responses to the Problem of Poor-Quality Blood*, in BLOOD POLICY: ISSUES AND ALTERNATIVES 21, 21-23 (David B. Johnson ed., 1977); Havighurst, *Trafficking*, *supra* note 185, at 7; Kessel, *supra* note 41, at 276-79.

225. Mitchell, *supra* note 214.

similar approach be used with more risky forms of body product supply, combining the goals of a safe and adequate supply for patients with the promotion of overall health by caring for suppliers?²²⁶ Moremarrowdonors.org wants to experiment with compensation in the form of financial benefits, but we could also consider non-cash compensation designed to promote the public health. In the 1950s, a pint of blood earned some suppliers free blood for themselves and their immediate families for a year, if needed, through blood assurance programs.²²⁷ Similar schemes have been suggested for organ donation, such as providing preferential positions on the waiting lists to previous living donors.²²⁸ These historical examples help us to evaluate current proposals, reminding us to consider how supplier compensation schemes could be shaped not only to obtain an adequate and safe supply, but also as opportunities to intervene in the health of suppliers and/or their families in the service of broader public health goals.

As we remember these prior medical visions, it is also important to consider why the actions of early twentieth-century doctors are useful, but insufficient, as a basis for the important project of theorizing and regulating body property. While those actions provide positive examples, they also were constrained by the self-interest and self-regard of the medical profession and of individual doctors. Doctors assumed their right and ability to buy and sell body products and also assumed that medical professional discretion was the best tool for allocating such supplies and medical treatment generally. Mothers' milk stations, for example, reflected the gender and class assumptions of their white, male, well-educated founders. Blood banks reflected the racism of the lay and medical public. For good reasons, scholars and policy makers have long been leery of the idea that doctors invariably act in the best interest of each patient or of the public at large.²²⁹ The battle of the blood banks clearly demonstrated that even within the medical community there was never a universally recognized vision of the best way to create and manage a body product supply. There is a significant difference between a general professional vision, even when based in expertise and public-

226. A related suggestion is the altruistic "intermediate" exchanges considered in Choi et al., *supra* note 59, at 298-308.

227. SWANSON, *supra* note 4, at 109.

228. Choi et al., *supra* note 59, at 297.

229. The long history of medical experimentation provides numerous examples, stretching at least as far back as early modern grave-robbing by medical students. See *supra* note 30. For particularly notorious examples, consider Dr. J. Marion Sims, the fate of cells taken from Henrietta Lacks, and the cells taken from John Moore. See *supra* notes 23, 35; see also SUSAN E. LEDERER, *SUBJECTED TO SCIENCE: HUMAN EXPERIMENTATION IN AMERICA BEFORE THE SECOND WORLD WAR* (1995); SUSAN M. REVERBY, *EXAMINING TUSKEGEE: THE INFAMOUS SYPHILIS STUDY AND ITS LEGACY* (2009).

mindedness, and the legislative processes of deliberation, participation, and rule-making that create formal law.

The medical visions I have traced, using blood and milk as examples, are also insufficient because body products vary. As discussed in Part II, they vary in the risks of harvesting and in their benefits to recipients. A sick baby might be able to recover using an artificial formula or human milk, while a hemorrhaging patient might only survive given a prompt transfusion. Organ transplants can extend lives for years; donor gametes create new lives in being. Further, the historical record shows that over time the demand for body products changes, making (for example) the rough surveillance and control surgeons exercised over individual blood sellers in the 1910s and 1920s impossible to maintain as the volumes used in each hospital increased, leading to community blood banks. Systems based on professional norms and ethics may break down when body product exchanges are occurring at much higher volumes, at a distance, and/or via on-line exchanges. For these reasons, the motivation and actions of Bernard Fantus in 1937 cannot be an unquestioned foundation for body product regulatory policy in 2017, nor can the tactics of milk market management be transferred unquestioned into kidney procurement.

Body product differences require that each body product should be considered and regulated independently. These regulations can take the form of body product specific legislation, like NOTA and blood shield laws. Allowing body products to be recognized as property, and property that is sometimes traded in markets, will also have ripple effects through the law, requiring the thoughtful interpretation of existing doctrines, in areas such as tort, contract, and tax law.²³⁰ As courts draw upon existing common law doctrines and legislatures consider statutory interventions, they can follow the lead of medical professionals by acknowledging that human-sourced therapeutics are property that can and should be created and exchanged for a purpose broader than each individual transaction and should be judged accordingly.

VII. CONCLUSION

Body property is now part of sociocultural and medical perceptions of ourselves as a result of a biomedical worldview developed over the last century. We believe there is valuable property in our bodies because we believe that we can be healed and enhanced by the application of biomedical science, a science that deconstructs and reconstructs the body into a source of fungible materials. That belief, and that promise, is what we foster by acknowledging such property within law.

230. See, e.g., Crawford, *supra* note 37, at 717-18; Krawiec, *Sunny Samaritans*, *supra* note 53; Milot, *supra* note 37; sources cited *supra* note 224.

To that starting point, that body products advance our health, we can add the ideal that healthcare should be allocated to those who need it, rather than only, or preferentially, to those who can buy it. This ideal remains a powerful strand within the American medical community and within the public at large, although the best means of implementing it remains highly contested in American politics.²³¹ Even a blood bank administrator known for her ferocious opposition to “free blood” in the Cold War era and for her dedication to running her bank just like a financial bank maintained a sense that her institution was *not* just another business, but instead like “fire, police, [and] trauma service,” that is, like community-financed organizations available to whoever needs help, whenever they need help.²³² The public good is implicated, as well as private needs.

The last century of experience with body products points the way for rethinking body property and its ends. By denaturalizing the gift/commodity dichotomy and rejecting the standard narrative, we can remember that the treatment of body products as property does not require the abandonment of the products themselves or their suppliers to the free market. Neither does owning property sourced from human bodies, and even exchanging such property in markets, preclude the type of relations between people linked by bonds of generosity and gratitude. Keeping these lessons in mind, we can use property law as a framework from which to regulate different types of body product management organizations and exchanges. Some body products might be best collected and allocated through democratizing institutions that increase access to a needed medical therapeutic to all those who could benefit by such treatment. Other body products may be successfully managed through *laissez faire* institutions of capitalism that facilitate the transfer of medical therapeutics to those willing to pay, as long as profiteering at the expense of supplier and recipient health is kept in check. The extent to which we regulate a body product market should reflect the body product itself, those who supply it, and those who use it, all guided by a positive vision of its use, rather than the blinders of the gift/commodity dichotomy or our prejudices and fears.

231. See Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (ruling on the constitutionality of the Affordable Care Act); Mark A. Levine et al., *Improving Access to Health Care: A Consensus Ethical Framework to Guide Proposals for Reform*, HASTINGS CTR. REP. 14, 15-16 (2007).

232. HEMPHILL, *supra* note 154, at 69.

