

Re-Framing the Gift of Life: An Examination of Altruism, Social Distance, and Material Incentives as Factors in Non-Directed Kidney Donor Motivation Among Nurses

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The purpose of this research is to examine motivations for undergoing a living kidney donation among professional helping service workers—specifically, nurses—using a research design reproduced from an earlier investigation evaluating the persuasiveness of the National Kidney Foundation’s (NKF) altruistic “gift of life” frame. Because the earlier study revealed limits to altruism and suggested, as a means to enhance the rate of living donations, strategic “re-framings” that address material incentives and donor-recipient relationships, we assessed in this study the motivations of key representatives of the caring professions. An international sample of 60 nursing professionals participated in a survey assessing the relationship between material incentives, social distance, and donor motivation. The results show a significant negative relationship between altruism and donor motivation and strong support for material incentives as a complement to living kidney donation. We consider the values and demands of the nursing profession, including the elevated risk of compassion fatigue, as a potential mitigating factor bearing on the willingness of individuals to give the “gift of life.” It is necessary to supplement this study with additional research by nephrology social workers and allied care professionals to both recognize and address the different factors influencing motivation for living kidney donation.

INTRODUCTION

According to the Organ Procurement and Transplantation Network [OPTN] (2013), more than 98,000 individuals are currently listed for a kidney transplant in the United States. Due to an ongoing kidney shortage, however, thousands of these individuals are expected to die prior to receiving a life-saving transplant. The active waiting list has grown to three times the available supply of donor kidneys and live organ donations—the preferred source for transplant surgeons—have continued to decline to just 1.2 transplants per 100 patient years on dialysis in 2011 (DHHS, 2011; USRDS, 2013).

The need to increase the rate of live kidney donations presents an ongoing challenge not only for patients and their families, but also for transplant teams, nephrologists, nurses, and social workers. Given the Institute of Medicine’s mandate for inter-professional social work-nursing collaborative practice within the healthcare system, those on the front lines of the organ shortage are uniquely positioned to work together across disciplines to collect relevant data and develop meaningful solutions that better address supply-side issues and dynamics (La Motte, 2012).

In one of the few studies of its kind, Humphries, Conrad, Berry, Reed, and Jennings (2009) provide empirical evidence of altruistic and other motivations among individuals related and unrelated to kidney recipients, arguing that how the National Kidney Foundation (NKF) and related organizations “frame” the organ shortage may help to increase the living donor pool. For several decades, the NKF has framed

living donation as a “gift of life” (Fox & Swazey, 1978; 1992, p. 33). In this research, we build upon and extend the work of Humphries et al. (2009) in examining the persuasiveness of this “gift of life” frame by focusing on the factors that influence non-directed kidney donation among an international sample of nurses. The critical role that nurses play as healthcare and helping professionals, we argue, is instrumental in shaping how individuals understand and respond to health challenges, including live organ donation.

Following Humphries et al. (2009), we first explore the social factors that motivate nurses to become living kidney donors. Second, we examine the willingness of nursing professionals to give to various recipients, using an established measure of social distance. We are particularly interested, with regard to social distance, in the unique demands of the nursing profession and the potential effect of compassion fatigue on the willingness to donate to unrelated recipients (Figley, 1995). Third, we explore the appeal among nurses of the use of material incentives relative to “gift of life” altruism in the framing of living kidney donations.

FRAMING THE GIFT OF LIFE: ALTRUISM AND INCENTIVES

As transplant rejection has taken a backseat to the issue of organ availability and integrity within the transplant community, meeting the challenge of an ongoing organ shortage has moved a growing number of scholars and commentators to reconsider how the NKF and other interested parties might “re-frame” live organ donation (Matas, 2007, p. 2). The literature on social movements defines collective action

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“frames” as slogans or catchphrases strategically designed by movement entrepreneurs to persuade target audiences (for a review, see Benford & Snow, 2000). Movement scholars contend that such messages have the potential to recruit members to an organization, or followers to a cause, often by tapping culturally “resonant” beliefs in ways that facilitate mobilization (Snow & Benford, 1988). The concept of “frame resonance” thus provides a necessary counterpoint to the more deliberate activity of framing in that it encompasses broader cultural notions that are commonly taken for granted (Snow, Rochford, Worden, & Benford, 1986; Williams, 2004).

In their examination of organ transplantation, Fox and Swazey (1992) contend that the “gift of life” frame has rhetorical power because it embodies the culturally “resonant” or commonly held ethics of volunteerism and freedom of choice (p. 33). It also recasts living donors as folk heroes, members of a special class of persons ready and willing to sacrifice a part of themselves for purely altruistic reasons (p. 33).

In their empirical examination of donor motivation, however, Humphries et al. (2009) find that altruism is significantly related to the willingness of individuals to donate a kidney only for immediate family and close friends and that strategic re-framings of the “gift of life” that include limited material incentives should be explored as a means to improve the rate of living kidney donations. Although Humphries et al. (2009) find little support for direct monetary compensation as a persuasive material incentive, they address the controversial claim among some commentators, including some notable medical professionals, that altruism alone is insufficient to motivate individuals to donate a kidney, particularly to an unrelated recipient, and that material incentives are necessary (McKenzie, 2007; Satel, 2011).

Debates over the desirability of material incentives offered as a supplement to live organ donation rest largely on ethical considerations related to the exploitation of the poor in a global market that “trafficks” in illegally acquired organs (Castillo, 2013; Satel, 2011). Reports of illegal organ sales are now widespread in many major news outlets, with the World Health Organization estimating that approximately 10,000 black market transplant operations are performed every year (Bilefsky, 2012; Campbell & Davison, 2012; Smith, 2011). Alongside the growing incidence of anecdotal reports is the release of a 2013 HBO documentary entitled “Tales from the Organ Trade,” which provides an inside look at the once-thriving black market in organs, led principally by the harvesting of kidneys, in the Philippines (Lynch, 2013).

Payment for organs is illegal in the majority of countries in the world (Campbell & Davison, 2012). Some commentators allege that any payment, even for transplant expenses or future medical care, carries the potential to turn the poor, particularly those in the developing world, into “spare parts” for the rich (Fox & Swazey, 1992). Others call for legalizing organ sales to stem the more abhorrent practices, including

unsafe procedures, lack of informed consent, and unfulfilled promises of payment, associated with what is increasingly acknowledged as an irreversible and growing global industry (Satel, 2011).

We incorporate these ethical concerns into our analysis by utilizing a value-added ethical-motivation scale developed by Humphries et al. (2009) that allows us to assess supportiveness among nurses for living kidney donation simultaneous with support for material incentives of increasingly greater value. As Humphries et al. (2009) argue, “identifying an ethically-based tipping point beyond which individuals may be less supportive of linking material rewards to living kidney donations is critical to determining whether or not and what kind of material incentives should be incorporated into the ‘gift of life’ frame” (p. 22). In the present study, we use frame theory to determine if material rewards have “resonance” for those working within a caring profession.

NURSES, ALTRUISM, AND THE GIFT OF LIFE

At the core of nursing, a profession that developed as a response to care for the sick, is the desire to have concern for others (Baer, 2009). This desire to care for others leads to compassion satisfaction as a characteristic of the profession through “the ability to receive gratification from caregiving” (Simon, Price, Roff, & Klemmack, 2006, p. 6). Nurses are experts with the knowledge to eradicate diseases, improve patient conditions, maintain health, or return patients to a previous state of health (Milton, 2012). Due to their education and fundamental foundation in a caring, trusting profession, it would seem that nurses would be more motivated to consider living kidney donation based on either altruistic principles or material incentives or both. However, it must be considered that nurses are also more knowledgeable of the potential risks of surgery and lifelong recovery with the potential need for lifestyle changes. Nurses may also have negative opinions about life choices that increase the need for kidney donations, with questions as to whether the patient will make adjustments that would increase the success of the transplant. As with the general public, more research is needed on nurses’ opinions about motivation, judgment, risk appreciation, liability risk, and ethics relative to non-directed kidney donation (see e.g., Jendrisak et al., 2006).

Altruism in particular is considered core to the nursing profession. The American Association of Colleges of Nursing (AACN) includes altruism as one of five professional values that guide nurses to ethical patient care and “epitomize the caring, professional nurse” in both the Bachelor of Science in Nursing (BSN) and Master of Science in Nursing (MSN) Essentials (AACN, 2011, p. 27). Altruism is explained by the AACN (2008) as concern for the well-being of others, including nurses’ concern for clients, other nurses, and other healthcare providers. The other professional values include autonomy, human dignity, integrity, and social justice. In order for baccalaureate and master’s nursing education programs to be accredited in the United States, they must

demonstrate that altruism is a component of the curriculum. Activities that demonstrate altruism, according to the AACN (2008), include: understanding the cultures, beliefs, and perspectives of others; advocating for clients, especially the most vulnerable; addressing the risk behaviors of clients; and mentoring professionals.

We contend that the “gift of life” frame should resonate with nurses because it is an altruistic appeal consonant with the values of the nursing profession. However, because nurses assume the caregiver role for patients, they may suffer from compassion fatigue as a component of their work, in contrast to compassion satisfaction. Compassion fatigue is defined as a combination of “work-related, physical, and emotional symptoms associated with caring for patients in physical distress” (Lombardo & Eyre, 2011). The risk of compassion fatigue is high in that nurses are often expected to take on more responsibilities and work in poorly-staffed units with high patient-to-staff ratios, which may lead to high nursing turnover and work dissatisfaction, poor patient outcomes, and decreases in the quality of care provided (Bodin, 2008; Moody & Pesut, 2006). Due to these working conditions, compassion fatigue may emerge gradually throughout a nurse’s career, leading to symptoms of chronic stress and negative attitudes reflecting a sense of “burnout” that involves “a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations” (Figley, 1995, p. 11). Hence, compassion fatigue may serve as a barrier to altruistic motives for non-directed kidney donations by nurses (Watson, 1988, p. 8).

We explore donor motivation among nurses using the Bogardus Social Distance Scale (Bogardus, 1925; 1933) as a measure of willingness to donate. We expect that the less the social distance between the donor nurse and recipient, or the closer their social relationship, the more favorable the respondent will be toward live kidney donation. We are particularly interested, given their role as care providers, in support among nurses for non-directed donation for purely altruistic reasons. Traditionally, living kidney donors have been immediate family members who are pressured toward altruism (Fox & Swazey, 1992, p. 33; Matas, 2007, p. 8). Like nephrology social workers, nurses are often expected to show empathy to patients as a component of altruism by identifying emotionally with the experiences of others (McCamant, 2006). Nurses and social workers are also often held to high standards, relevant to their respective working conditions, and possess knowledge of transplantation risks that are lacking in other populations. These factors may suggest the need for “re-framings” of non-directed kidney donation for this population that tap cultural meanings other than altruism. In so doing, this research helps nephrology social workers understand the importance of collaboration with their nursing counterparts to provide a comprehensive understanding of live kidney donations.

RESEARCH DESIGN AND METHODS

Conceptualization and Measurement

This exploratory study uses the Bogardus Social Distance Scale (Bogardus, 1925; 1933) to assess the willingness of nurses to undergo a living kidney donation, based on their social proximity to the recipient. This scale is generally used to measure respondents’ level of comfort associating with people who are different in some fundamental way, on the assumption that this difference is a marker of social distance (Babbie, 2004; Neuman, 2000). Humphries et al. (2009) were the first to use it as an indicator of the willingness of individuals to donate a kidney to close or distant others. Following that study, we use the Bogardus Social Distance Scale as follows:

1. I would donate one of my kidneys to a member of my immediate family.
2. I would donate one of my kidneys to members of my extended family (e.g., aunt, uncle).
3. I would donate one of my kidneys to a close friend.
4. I would donate one of my kidneys to an acquaintance or a friend of a friend.
5. I would donate one of my kidneys to a stranger.

As explained by Humphries et al. (2009):

The Bogardus Social Distance Scale assumes that individuals who would donate their kidney to a stranger would also donate a kidney to an acquaintance, a close friend, members of their extended family and their immediate family. Based on their responses to this one to five scale, respondents were grouped into distance levels, which we used as an indicator of altruism (e.g., individuals who answered “yes” to item five were categorized as more altruistic than individuals who answered “yes” to item four but “no” to item five). This allowed us to measure the intensity of respondents’ altruism with regard to the “gift of life.” (p. 23)

To measure the appeal of material incentives, we use a cumulative summated-rating scale that links various material rewards to living kidney donation (Humphries et al., 2009). This Ethical-Motivation scale consists of nine dimensions of increasingly valuable material incentives. On a scale of 1 to 5, with 5 being the most favorable, nurse respondents were asked to indicate the extent of their agreement with each of nine statements used as an indicator of donor motivation. These nine items are as follows:

1. Living kidney donors should not be compensated. The donation should be considered a free-will donation and purely altruistic.
2. Living kidney donors should be entitled to compensation for medical expenses related to the procedure.

3. Living kidney donors should be entitled to compensation for medical expenses and lost wages relating to the procedure.
4. Living kidney donors should be compensated for medical expenses, lost wages related to the procedure, and should receive a “reward” package that may include a weekend getaway.
5. Living kidney donors should be compensated in the form of a Federal deduction tax incentive.
6. Living kidney donors should be compensated for medical expenses and lost wages relating to the procedure and should also receive a “reward” package that may include cash or tax credit incentives.
7. Living kidney donors should be compensated for medical expenses and lost wages relating to the procedure and should also receive a “reward” package that includes life-long medical coverage.
8. Living kidney donors should be compensated for medical expenses and lost wages relating to the procedure and should also receive a “reward” package that includes life-long medical coverage, plus an amount of instant compensation up to \$60,000–\$70,000.
9. Living kidney donors should be able to freely negotiate the price, compensation, and reward they receive for their donation with no limitation on the amount or criteria.

Data Collection

Data for this research is based on a self-administered, self-reported survey using a non-representative sample of convenience from an international nursing conference in August 2013 in Prague, Czech Republic. The study was approved by the Pittsburg State University Committee Involving the Use of Human Subjects. Although the sample represents 18 different nationalities, the U.S. is over-represented. A total of 57 nurses out of 60 completed the survey, with 3 surveys missing data (RR = 100%). Sample demographics are presented in [Table 1](#).

Data Analysis

SPSS 20 was utilized for the statistical analysis of survey data. We rely primarily on descriptive statistics, including frequency counts and cross-tabulations and the calculation of means and standard deviations. A Cronbach’s alpha was used to test the Ethical-Motivation scale for internal consistency and reliability and produced a result of $\alpha = 0.81$ (Voght, 2005, p. 71). The relationship between the Ethical-Motivation scale and the Bogardus Social Distance Scale was examined using a Spearman correlation technique.

RESULTS

The first objective in this study is to assess the willingness of care professionals—specifically, nurses—to donate a kidney to related and unrelated recipients. Like Humphries et al. (2009), we hypothesize that those who have the least social distance from the respondent will be the most likely choice for a donation and use the Bogardus Social Distance Scale (Bogardus, 1925; 1933) as our test. The data in [Table 2](#) support the hypothesis that increased social distance decreases altruistic motivation. Specifically, although there is a strong willingness to donate to a member of one’s immediate or extended family, only 22.8 percent of respondents indicated that they were willing to donate a kidney to an acquaintance and 15.8 percent to donate to a complete stranger. Hence, 77.5 percent fewer nurse respondents were willing to donate a kidney to a stranger than to an immediate family member. This result is statistically significant at the $p > .05$.

A second purpose of this study is to understand the motivations of potential donors who work in a caring profession that values altruism as a professional goal. A nine-statement Ethical-Motivation scale, first developed by Humphries et al. (2009), was used to examine the amount of support among nurses for increasing material incentives. As illustrated in [Table 3](#), respondents agreed that living donors should be able to freely negotiate compensation without limitation (3.96). They also agreed that living donors should receive compensation for medical expenses, lost wages, and an instant cash payout of up to \$60,000 to \$70,000 (3.77). In declining order of importance, less support was expressed for 1) a reward package consisting of compensation for medical expenses, lost wages, and a weekend getaway (3.20);

Table 1: Demographic Characteristics of the Sample

					Totals
Gender	<i>Males</i>	<i>Females</i>	<i>No Answer</i>		
	1.6% (n = 1)	76.6% (n = 46)	21.8% (n=13)		100% (N = 60)
Age	<i>21-30</i>	<i>31-40</i>	<i>41-50</i>	<i>51-70 +</i>	
	3.38% (n = 2)	16.9% (n = 10)	16.9% (n = 10)	62.7% (n = 37)	100% (N = 59)
Education	<i>Bachelor</i>	<i>Masters</i>	<i>Doctorate</i>	<i>Other</i>	
	1.6% (n = 1)	18.3% (n = 11)	75.0 % (n = 45)	3.3% (n = 2)	100% (N = 60)

Years in Practice Mean = 24.86 Mode = 30 Median = 27

Table 2: Social Distance and Kidney Donation (N = 60)

	Yes	No
I would donate one of my kidneys to an immediate family member	93.3% (n = 56)	6.6% (n = 4)
I would donate one of my kidneys to a member of my extended family	65.0% (n = 39)	35.0% (n = 21)
I would donate one of my kidneys to a close friend.*	66.5% (n = 27)	53.4% (n = 31)
I would donate one of my kidneys to an acquaintance.*	22.8% (n = 13)	77.2% (n = 44)
I would donate one of my kidneys to a stranger.*	15.8% (n = 9)	84.2% (n = 48)

*Missing Data

2) compensation for medical expenses, lost wages, and a tax credit (3.18); and 3) life-long medical coverage (3.15). Respondents expressed little support for compensation packages involving 1) a Federal tax deduction (2.69); 2) lost wages (1.74); or 3) medical expenses (1.72). Free will, altruistic donations also received little support (2.34).

As illustrated in [Table 4](#), a statistical examination of the relationships between the statements comprising the Social Distance Scale and the Ethical-Motivation Scale revealed positive correlations between willingness to donate a kidney to a member of one's immediate or extended family and a variety of material incentives, including: 1) compensation for medical expenses; 2) a Federal tax deduction; and 3) a reward package involving a weekend getaway. Also positive was the relationship between willingness to donate to an

immediate family member and reward packages involving 1) medical expenses, lost wages and lifelong medical coverage; 2) medical expenses, lost wages, lifelong medical coverage and a cash payout; and 3) freely negotiated unlimited compensation. Willingness to donate to an unrelated other, namely an acquaintance, was also positively correlated with a reward package involving compensation for medical expenses and lost wages.

Except for the relationship between a reward package involving medical expenses, lost wages and a weekend getaway and willingness to donate to an immediate family member, none of these positive relationships were statistically significant. Willingness to donate a kidney to a distant or close other was negatively correlated with support for all other material incentives. Perhaps most striking of these negative correla-

Table 3: Supportiveness for Linking Material Incentives to Living Donation (N = 60)

	Mean	SD
1. Living kidney donors should not be compensated. The donation should be considered a free-will donation and purely altruistic.	2.34	1.32
2. Living kidney donors should be entitled to compensation for medical expenses related to the procedure.	1.72	1.57
3. Living kidney donors should be entitled to compensation for medical expenses and lost wages related to the procedure.	1.74	1.10
4. Living kidney donors should be compensated for medical expenses, lost wages relating to the procedure and should also receive a "reward" package that may include a weekend getaway.	3.20	1.50
5. Living kidney donors should be compensated in the form of a Federal tax deduction.	2.69	1.50
6. Living kidney donors should be compensated for medical expenses and lost wages relating to the procedure and should also receive a "reward" package that may include cash or a tax credit.	3.18	1.44
7. Living kidney donors should be compensated for medical expenses and lost wages relating to the procedure and should also receive a "reward" package that includes life-long medical coverage.	3.15	1.39
8. Living kidney donors should be compensated for medical expenses and lost wages relating to the procedure and should also receive a "reward" package that includes life-long medical insurance coverage plus an amount of instant compensation of up to \$60,000–\$70,000.	3.77	1.30
9. Living kidney donors should be able to freely negotiate the price, compensation, and reward they receive for their donation with no limitation to the amount or criteria.	3.96	1.29

Table 4: Correlations Between Social Distance and Support for Material Incentives

	Immediate Family	Extended Family	Close Friend	Acquaintance	Stranger
Altruism	-.235*	-.073	-.176	-.254*	-.234*
Medical expenses only	.051	.125	-.026	-.017	-.028
Medical expenses and lost wages	-.003	-.173	-.191	-.083	.000
Medical expenses, lost wages, and weekend getaway	.231*	.026	-.029	-.085	-.029
Federal tax deduction	.167	.057	.045	.036	-.090
Medical expenses, lost wages and cash or a tax credit	-.003	-.173	-.191	-.083	.000
Medical expenses, lost wages, and lifelong medical coverage	.153	-.064	-.011	.069	-.051
Medical expenses, lost wages, lifelong medical coverage, and a lump-sum cash payout	.171	-.110	-.009	-.026	-.194
No limits to compensation	.148	-.153	-.027	-.047	-.204

** $p < .01$, 1-tail test

* $p < .05$, 1-tail test

tions are those between willingness to donate to an immediate family member, acquaintance or stranger, and altruism, with these negative correlations being statistically significant at the $p < .05$ level.

DISCUSSION

Using the research design of Humphries et al. (2009), this research assesses the effectiveness of the NKF's altruistic "gift of life" frame on kidney donor motivation among nurses. Like Humphries et al. (2009), we provide empirical evidence, using the Bogardus Social Distance Scale (Bogardus, 1925; 1933), that individuals are willing to donate a kidney to close others (e.g., a member of their immediate family) but less willing to donate to an acquaintance or stranger. However, we found a lower overall willingness to donate a kidney among nurses versus a comparable sample of college-going adults (Humphries et al., 2009). Future research should look at other healthcare and helping professions (like social work) utilizing this research design and consider qualitative initiatives to explore how to increase altruistic motivation. In this study, the nurses had an average of 25 years of practice. This population could potentially have high levels of compassion fatigue and further research should investigate this as a factor in their decisions. A compassion fatigue questionnaire could be utilized along with this study to determine significance, since nurses had a lower motivation rating than college-going adults (Humphries et al., 2009).

More importantly, we found through an assessment of support among nurses for material incentives, that altruism alone does not resonate with those in a profession

characterized by caring. Our respondents were supportive of a variety of material rewards linked to living kidney donation, with the strongest support expressed for reward packages involving lump-sum cash payouts or in which the relevant parties were able to freely negotiate compensation without restriction. These findings contrast with those of Humphries et al. (2009), which show that direct cash rewards are not especially compelling as a motivating factor for living kidney donation. There is limited research or theory development to explain why nurses are motivated to care, yet this is a critical element of nursing (Moody & Pesut, 2006).

Given the important role nurses play as frontline professionals in shaping how individuals understand and respond to health challenges, it is necessary to understand their perspectives and experiences. With regard to social distance, it is important to consider the demanding nature of the nursing profession and the extent to which it may increase the risk of emotional exhaustion, depersonalization, and a sense of reduced personal accomplishment, which may drive a wedge between the relationship of nurses to their patients. The experience of compassion fatigue, along with a heightened knowledge of the ethical dilemmas and risks associated with transplantation and live organ donation, may lead to a more practical orientation among nurses in which material incentives are valued over pure altruism.

Although the offering of material rewards as an incentive to live organ donation continues to be a controversial issue, evidence is accumulating, aided in part by the present study, that suggests that altruistic appeals alone are insufficient to motivate individuals to donate a kidney, particularly to

recipients who are not known to the donor. Humphries et al. (2009) contend that strategic re-framings that tap cultural understandings other than altruism are necessary to address the challenge of an ongoing organ shortage. Because these authors find evidence of an ethical tipping point beyond which material incentives seem distasteful, they argue in favor of limited material incentives framed in a language of “rights.”

The present study makes an even stronger case for re-framing the “gift of life” by uniting two distinct ideologies—one rooted in ethics and the other in the language of the market—under a single rhetorical banner, an alignment technique social movement scholars refer to as “frame bridging” (Snow et al., 1986). We argue that nurses, in particular, are credible claims-makers, whose professional experiences and values may lead them to regard material compensation as a just reward for the otherwise disadvantaged, particularly those living donors for whom financial security might be necessary to preserve their “right” to autonomy, dignity, and integrity. Hence, the values of the nursing profession, as articulated by the American Association of Colleges of Nursing (2011), can perhaps be used to combine market messages of personal worth and wealth with altruistic notions of generosity and self-sacrifice to create a persuasive message campaign. Like social workers, nurses are familiar with both patient rights and themes of social justice and may assist in interdisciplinary efforts that shed light on the contributions of these professional values to efforts to reframe the “gift of life.”

Most importantly, the present study points to the value of theoretically-informed analyses that measure the “resonance” of various health-related messages for a target audience as a means to solve our most pressing healthcare challenges, including the problem of a persistent organ shortage. Because the “gift of life” message lacks the resonance necessary to persuade nurses to undergo a living kidney donation, healthcare and helping professionals should seek ways to move beyond framing living organ donation in altruistic terms.

LIMITATIONS OF THE STUDY

Because the present study uses a similar exploratory research design to that used by Humphries et al. (2009), it shares many of the same limitations. These include a small, non-representative sample and the use of measures of attitudes (i.e., willingness to donate a kidney and support for linking various material rewards to living kidney donations) as “indicators” of motives, despite the imperfect correspondence between attitudes and motivations (Meyers, 1999). These limitations are outweighed, we think, by the differences between the results of the present study and those of Humphries et al. (2009). Given the critical need to find effective strategies to increase the organ supply, future analyses should further investigate the links between donor motivation, health-related frames and their relationship to healthcare and helping service professionals, like nephrology social workers.

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