Is the "Gift of Life" a Resonant Frame?

A Comparison of Factors Involved in Non-Directed Kidney Donor Motivation for Social Workers and Nurses

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This research examines kidney donor motivations using a research design from prior investigations evaluating the persuasiveness of the National Kidney Foundation's (NKF) altruistic "gift of life" frame. Because previous studies produced mixed results, showing in particular substantially more support for material incentives among an international sample of nursing professionals, as compared to a convenience sample of college students, we compared in this study the motivations among practitioners in the fields of nursing and social work. A total of 159 social workers and nurses participated in a survey that addressed the relationship between material incentives, social distance and motivation to donate, as well as work-related burnout and compassion fatigue as structural factors that might reduce non-directed kidney donor motivation. The results show a significant negative relationship between altruism and donor motivation, as measured by social distance between donor and recipient, and a strong lack of support for direct cash incentives as a complement to living kidney donation. The results also show little support for the notion that compassion fatigue or burnout accounts for these results. Social workers are somewhat more altruistic than nurse practitioners but the differences between the two groups are not meaningful. However, low support for living donations to unrelated others, coupled with high support for limited material incentives for both groups, suggest a continued need to explore alternatives to the current framing of kidney donations as giving the "gift of life."

INTRODUCTION

In the United States, critically ill patients often suffer as a result of a critical organ shortage. In 2015, the Organ Procurement and Transplantation Network (OPTN) reported more than 121,000 people in need of an organ transplant, with over 78,000 patients on the active wait list. Of over 28,000 transplants performed, 5,075 involved living kidney donations (OPTN, 2015). In 2015, approximately 12,000 potential kidney recipients either refused a transplant or died awaiting treatment, or were considered too ill for a transplant alone (OPTN, 2015).

This critical care issue has prompted some in the medical community to call for changes in policy pertaining to organ donation, particularly as it relates to the controversial issue of donor compensation. For example, a working group of 50 medical professionals from many regions of the world recently established guidelines for a regulated system of incentives for living organ donations and published these guidelines in the *American Journal of Transplantation* (Working Group on Incentives for Living Donation, 2012). New research on the motives of those who undergo a living kidney donation is therefore needed not only to improve the living donation rate, but also to better inform future policy development.

Humphries, Conrad, Berry, Reed, and Jennings (2009), and Humphries, Conrad, Giefer, Hite, and Bishop (2014) provide empirical evidence relevant to donor motivations, including the influence of cash and other material rewards, among individuals related and unrelated to kidney recipients. Importantly, both studies suggest that the National Kidney Foundation's (NKF) effort to frame living kidney donations altruistically as a "gift of life" is limited in its appeal (cf. Fox & Swazey, 1992). In this research, we extend the work of Humphries et al. (2009; 2014) by focusing on the social factors that may be relevant to the decisions of nurses and social workers to become living kidney donors. We specifically compare the views of nurses and social workers with NKF membership because of their potential knowledge base as front-line nephrology professionals and the opportunity they therefore provide to understand the problem of organ donation and the organ shortage in ways that may help to improve the current paradigm.

Following Humphries et al. (2009), we first explore the willingness of nursing and social work practitioners to donate a kidney to related or unrelated recipients using an established measure of social distance. Second, we explore the appeal of material incentives relative to "gift of life" altruism among nurses and social workers. Third, we examine the relationship between donor motivation and work-related factors, most notably compassion fatigue and worker burnout, as possible structural barriers that may impede the motivation to donate.

THE "GIFT OF LIFE" AND THE INCENTIVE DEBATE

A growing global market in illegally acquired organs has led an increasing number of health professionals to suggest that the NKF and other organizations reconsider how they "frame" the organ shortage, particularly as it relates to

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the provision of monetary and other material incentives (Matas, 2007; Salomon et al., 2015). "Framing" is a term relevant to a theoretical perspective rooted in the literature on social movements in the social sciences, which suggests that the ways in which movements communicate a problem to broader publics can serve to crystallize that problem in ways that create a sense of urgency (Snow, Rochford, Worden, & Benford, 1986). Collective action "frames" are typically defined as persuasive slogans or catchphrases designed strategically by movement entrepreneurs (Benford & Snow, 2000). Persuasive frames successfully tap culturally "resonant" or taken-for-granted ideas and are therefore likely to recruit potential followers to a cause (Snow & Benford, 1988).

In their work on organ transplantation, Fox and Swazey (1992) suggest that living donors are elevated to folk heroes as a consequence of their choice to sacrifice a part of themselves for altruistic reasons (p. 33). Giving the "gift of life" is thus culturally "resonant" in that choice and volunteerism has wide appeal (Fox & Swazey, 1992, p. 33). In their research on donor motivation, however, Humphries et al. (2009; 2014) find that altruism alone is an insufficiently motivating "frame" and that, given the scope of the organ shortage, the kind of cash-based incentives, ones that Fox and Swazey (1992) claim would turn the poor into "spare parts" for the rich, may in fact be warranted. In a controversial piece, Satel (2011) claims that payment for organs could end the objectionable practices typically associated with prohibition, including unsafe procedures, lack of informed consent and cash promises that never materialize. Such ethical debates take on increased urgency in an environment in which one organ is sold every hour, according to the World Health Organization, with the majority of sales involving kidneys (Campbell & Davison, 2012).

In our opinion, social scientists should not shy away from debates surrounding "cash for organs" and other controversial ideas. Instead, ethical concerns should be incorporated into research models, particularly for studies that explore what motivates an individual to undergo living kidney donation surgery. Following Humphries et al. (2009), we incorporate ethical concerns into our analysis by utilizing a value-added Ethical-Motivation Scale to better determine the "resonance" among nurses and social workers of the idea that living kidney donors should be compensated. This, we argue, is critical to determining whether or not, and how, to incorporate material incentives into the "gift of life" frame (Humphries et al., 2009, p. 22).

NURSING AND SOCIAL WORK

Consistent with framing theory, we contend that the NKF's "gift of life" frame should resonate with both nurses and social workers in that practitioners undergo professional training and each discipline has a similar code of ethics rooted in a culture of care. This hypothesis is based on the idea that if one is socialized to believe and behave in a certain way in a professional setting, one would likely apply that same worldview to their personal decision-making.

Professional socialization has been defined as "the acquisition of the knowledge, skills, values, roles, and attitudes associated with the practice of a particular profession" (Clark, 1997, p. 442). Miller (2010) has adapted a professional socialization model for social workers from the literature on the socialization of medical and nursing students, which progresses from pre-socialization to formal socialization to practice after formal socialization. Doctors, nurses, and social workers complete programs of study that are practice- and competency-based; they each include a clinical or practicum component as part of education; and, they each include immersion into a professional culture with specific values and approaches (Barretti, 2004). Further, they each include continued socialization through formal and informal education once in practice.

Each profession also has a specialized knowledge base, and the overarching values of the profession influence the way professionals carry out practice. Social work programs introduce students to the National Association of Social Workers (NASW) Code of Ethics, which informs social work students that the mission of social work is to "enhance human well-being and help meet the basic human needs of all people…" (NASW, 2008). The NASW Code of Ethics lists six core values of the profession: "service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence" (NASW, 2008). The social work value, "service," tells future and current social workers that they are "encouraged to volunteer some portion of their professional skills with no expectation of significant financial return" (NASW, 2008). Social work students are also introduced to a particular worldview in that the profession is "guided by a person in environment framework" (CSWE, 2015, p. 5). Social work students are educated to view clients through an ecological or bioecological model, as opposed to a "medical model," which is seen as more focused on the disease than on the person.

Similarly, according to the American Association of Colleges in Nursing (AACN, 2008), training in ethical patient care emphasizes the professional values of altruism, autonomy, human dignity, integrity, and social justice. Altruism includes understanding the cultures, beliefs, and perspectives of others, advocating for clients, especially the most vulnerable, addressing the risk behaviors of clients, and mentoring professionals (AACN, 2008). In contrast to social workers however, nursing students are more likely to complete their clinical experiences immersed in the medical model. Clark (1997) argues that medical professions value rational solutions to medical problems and a "disinterested concern for patient and society" (p. 443). As a part of their formal medical training, nurses are also more knowledgeable of the potential risks of surgery and the difficulties associated with recovery. This knowledge and training, we argue, results in a more "pragmatic" as opposed to "idealistic" approach, particularly among nursing practitioners.

In the present study, we hypothesize that both social workers and nurses should be oriented towards altruism, but that nurses will be less altruistic than social workers. Following Humphries et al. (2009), we utilize the Bogardus Social Distance Scale (Bogardus, 1925; 1933) to measure altruism in both populations. Specifically, we hypothesize that the less the social distance between donor and recipient, the greater the willingness to donate. In addition, to determine whether or not working conditions foster social distance, and thus decrease donor motivation, as suggested originally by Humphries et al. (2014), we incorporate a Compassion Fatigue Scale designed to measure work-related stress and burnout as potential barriers to living kidney donation (Watson, 1988, p. 8).

RESEARCH DESIGN AND METHODS

Conceptualization and Measurement

Following Humphries et al. (2009; 2014), we assess the willingness of NKF member nurses and social workers to undergo a living kidney donation with a modified version of the Bogardus Social Distance Scale (Bogardus, 1925; 1933), which is regarded as a valid measure of the level of comfort individuals have in associating with individuals who are increasingly "distant" or dissimilar on various key traits (Babbie, 2004; Neuman, 2000). This scale is 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 a member of my extended family (e.g., aunt, uncle).
3. I would donate one of my kidneys to a close friend.
4. I would to 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.

Responses to these items were scored from 1 to 5, with individuals who answer "yes" to item 5 categorized as more altruistic than individuals who answered "yes" to item 4 but "no" to item five. This scale thus served as an indicator of the intensity of respondents' altruism.

Also following Humphries et al. (2009; 2014), we use a cumulative summated-rating scale linking various material rewards to willingness to donate. This ethical-motivation scale (FMS) was developed in accordance with ethical issues raised in the literature on donor compensation and consists of nine items of increasing monetary or material value. On a scale of 1 to 5, with 5 being the most favorable, respondents were asked to indicate the extent of their agreement with each of 9 statements. These 9 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 tax deduction 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.

To measure compassion fatigue, we use an 11-item summated rating scale, again using issues raised in the literature on burnout and compassion fatigue (Figley, 1995; Lombardo & Eyre, 2011; Smith, Preston, & Humphries, 1976). Respondents were asked to indicate the extent of their agreement with each of 11 statements, rated on a scale of 1 to 5, with 5 being the highest level of compassion fatigue. These 11 items are as follows:

1. I feel like work dominates my life.
2. When personal problems arise I can rely on my coworkers for advice.
3. I have become emotionally detached in my professional and personal life.
4. I am frequently taking work home with me.
5. I seem to be working harder and accomplishing less.
6. I often feel physically and emotionally exhausted by the end of the work day.
7. When problems arise, sometimes I resort to drinking, drugs, gambling, or other methods of escape.

8. I often find myself questioning my competence and the effectiveness of my work performance.
9. It seems like my work goes unappreciated and unrecognized.
10. I find it difficult to form meaningful relationships outside the workplace.
11. I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek help.

Data Collection

Data for this research is based on a self-administered, self-report survey using a non-representative sample of convenience administered at the National Kidney Foundation 2015 Spring Clinical Meetings to social workers, nurses, and other healthcare professionals. A total of 169 respondents completed the survey, with 10 surveys missing data (RR = 100%). We confine our comparative analyses to 159 social workers and nurses but note that 10 other healthcare professionals completed the survey, yielding a total sample size of 169 respondents. The study was reviewed and approved by the Pittsburg State University Committee Involving the Use of Human Subjects. Table 1 illustrates the demographic characteristics of the sample.

Data Analysis

SPSS 22 was utilized for the statistical analysis of these data. Percentages and simple cross tabulations were used for nominal and ordinal variables to observe bivariate relationships. Descriptive statistics, including means and standard deviations, were used for the three ordinal-level scales. A Cronbach's alpha was used to test the reliability and internal consistency of the ethical-motivation scale and produced α = .82. The Cronbach's alpha for the modified Bogardus Social Distance Scale was α = .72 A Spearman correlation technique was used to examine the relationship between the social distance scale and the ethical-motivation scale.

Table 1. Demographic Characteristics of the Sample (N = 169)*

					Totals
Gender	Male	Female			
	8.3% (*n* = 14)	91.1% (*n* = 154)			99.4% (*n* = 168)
Age	21–30	31–40	41–50	51 or more	
	7.9% (*n* = 13)	23.8% (*n* = 40)	25.6% (*n* = 43)	38.1% (*n* = 64)	95.4% (*n* = 160)
Education	Bachelors	Masters	Doctorate	Other	
	7.7% (*n* = 13)	78.7% (*n* = 133)	4.1 % (*n* = 7)	8.3% (*n* = 14)	94.6% (*n* = 167)
Occupation	Nurses	Social Workers	Other		
	40.2% (*n* = 68)	53.8% (*n* = 91)	6.0% (*n* = 10)		100% (*n* = 169)

*Totals do not add to 100% due to missing data.

Table 2. Social Distance and Kidney Donation (N = 169)*

	Yes	No
I would donate one of my kidneys to a member of my immediate family.	95.8% (*n* = 161)	4.1% (*n* = 7)
I would donate one of my kidneys to a member of my extended family.	74.4% (*n* = 125)	25.6% (*n* = 43)
I would donate one of my kidneys to a close friend.	71.3% (*n* = 119)	28.1% (*n* = 47)
I would donate one of my kidneys to an acquaintance or friend of a friend.	22.9% (*n* = 38)	77.1% (*n* = 128)
I would donate one of my kidneys to a stranger.	14.5% (*n* = 24)	85.5% (*n* = 141)

*Totals do not add to 100% due to missing data.

Table 3. Social Distance and Kidney Donations, Nurses and Social Workers Compared (N = 159)*

		Nurses (*n* = 68)	Social Workers (*n* = 91)
I would donate one of my kidneys to a member of my immediate family.	Yes	92.6% (*n* = 63)	98.9% (*n* = 89)
	No	07.4% (*n* = 5)	01.1% (*n* = 1)
I would donate one of my kidneys to a member of my extended family.	Yes	69.3% (*n* = 47)	78.9% (*n* = 71)
	No	30.9% (*n* = 21)	21.1% (*n* = 19)
I would donate one of my kidneys to a close friend.	Yes	64.7% (*n* = 44)	76.4% (*n* = 68)
	No	35.3% (*n* = 24)	23.6% (*n* = 21)
I would donate one of my kidneys to an acquaintance or friend of a friend.	Yes	10.3% (*n* = 7)	34.1% (*n* = 30)
	No	89.7% (*n* = 61)	65.9% (*n* = 58)
I would donate one of my kidneys to a stranger.	Yes	03.0% (*n* = 2)	25.0% (*n* = 22)
	No	97.0% (*n* = 66)	75.0% (*n* = 66)

*Totals due not add to 159 due to missing data; p >.09 2 df (nurses) and p >.001 2 df (social workers)

RESULTS

The purpose of this exploratory study is to compare nurses and social workers on each of three measures used as indicators of kidney donor motivation: 1) social distance between donor and recipient; 2) support for material incentives as a component of motivation to undergo a living kidney donation; and 3) self-ratings concerning compassion fatigue and worker burnout as possible factors influencing donor motivations among nursing and social work professionals.

With respect to social distance, we used a modified Bogardus Social Distance Scale (Bogardus, 1925; 1933), based on the hypothesis that those with the least social distance from the respondent would elicit the most willingness to donate (Humphries et al., 2009; 2014). The data in Table 2 support the hypothesis that as social distance increases, the willingness of respondents to donate a kidney decreases. 95.8% of nursing, social work, and other healthcare respondents indicated they would donate one of their kidneys to an immediate family member. 74.4%, or 21.4% less, were willing to donate a kidney to a member of their extended family. 71.3%, or 24.5% less, were willing to donate a kidney to a close friend.

In contrast to the high willingness associated with donations to immediate and extended family, however, only 22.9% of nursing, social work and other healthcare respondents were willing to donate a kidney to an acquaintance and only 14.5% were willing to donate to a stranger. Hence, 81.3% fewer respondents were willing to donate a kidney to a stranger than to an immediate family member. This result is statistically significant at p >.001.

As indicated in Table 3, a comparison between nurses and social workers on the Bogardus Social Distance Scale (Bogardus, 1925; 1933) supports the hypothesis that social workers are more altruistic. Compared to nurses, social workers are 6.3% more willing to donate when it comes to donation to an immediate family member; 9.6% more willing when it comes to an extended family member; and 11.7% more willing when it comes to a close friend. In addition, despite the low level of willingness to donate to unrelated others among both groups, social workers are 23.8% more willing to donate to an acquaintance than are nurses, and 22% more willing to donate to a total stranger. Thus, the range of difference in willingness to donate to related and unrelated others is much greater in nurses at 89.6% (p >.09 2df) as compared to 73.9% for social workers (p >.001, 2df).

To examine the amount of support associated with material incentives of increasing value, we used a nine-statement ethical-motivation scale developed by Humphries et al. (2009). As illustrated in Table 4, nursing and social work respondents agreed that living donors should be compensated for medical expenses (4.63). They also agreed that donors should be compensated for lost wages (4.43) and should receive a federal tax deduction (3.42). High agreement was also expressed for non-compensated altruistic giving (3.62). In declining order of importance, less agreement was expressed for: 1) reward packages involving compensation for medical expenses, lost wages, and a tax credit/cash award and compensation for medical expenses, lost wages, and a weekend get-a-way reward package (2.77) 2) compensation for medical expenses, lost wages, and a reward package consisting of life-long medical coverage (2.74), 3) compensation for medical expenses, lost wages, life-long medical insurance, and an instant cash payout of up to $60,000 to $70,000 (2.05) and 4) free negotiation of price, compensation, and reward without limitation (1.77).

Table 5 illustrates the differences between social workers and nurses in their level of agreement about various material rewards as a complement to living kidney donation. Both nurses and social workers agree that donors should receive limited material rewards in the form of compensation for medical expenses and/or lost wages. For medical expenses in

Table 4. Linking Material Incentives to Living Donation (N = 169)*

	Mean	SD
Living kidney donors should not be compensated. The donation should be considered a free-will donation and purely altruistic.	3.62	1.27
Living kidney donors should be entitled to compensation for medical expenses related to the procedure.	4.63	0.64
Living kidney donors should be entitled to compensation for medical expenses and lost wages related to the procedure.	4.43	3.21
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.	2.77	1.96
Living kidney donors should be compensated in the form of a federal tax deduction.	3.42	1.32
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.	2.77	1.30
Living kidney donors should be compensated for medical expenses and lost wages relating the procedure and should also receive a "reward" package that includes life-long medical coverage.	2.74	1.28
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.	2.05	1.02
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.	1.77	.928

*Other healthcare professionals (*n* = 10)

Table 5. Linking Material Incentives to Donation; Nurses and Social Workers Compared (N = 159)

Incentives		**Nurses (*n* = 68)**	**Social Workers (*n* = 91)**
Altruism	*Mean*	3.76	3.57
	SD	1.27	1.25
Medical expenses only	*Mean*	4.60	4.69
	SD	0.58	0.61
Medical expenses and lost wages	*Mean*	4.28	4.56
	SD	0.93	4.29
Medical expenses, lost wages, and weekend getaway	*Mean*	2.62	2.84
	SD	1.34	2.37
Federal tax deduction	*Mean*	3.29	3.45
	SD	1.40	1.29
Medical expenses, lost wages and cash or a tax credit	*Mean*	2.67	2.75
	SD	1.28	1.29
Medical expenses, lost wages, and lifelong medical coverage	*Mean*	2.73	2.69
	SD	1.35	1.23
Medical expenses, lost wages, life-long medical coverage, and a lump-sum cash payout ($60K–$70K)	*Mean*	1.99	2.01
	SD	1.04	0.97
No limits to compensation	*Mean*	1.75	1.77
	SD	0.88	0.93

Table 6. Correlations Between Social Distance and Support for Material Incentives (N = 169)*

	Immediate Family	Extended Family	Close Friend	Acquaintance	Stranger
Altruism	.057	.074	.002	.036	.094
Medical expenses only	-.103	-.078	.006	.058	-.048
Medical expenses and lost wages	.070	.025	.028	.091	.013
Medical expenses, lost wages, and weekend getaway	.117	.008	.113*	.159*	.105
Federal tax deduction	-.066	.006	.174*	.166*	.071
Medical expenses, lost wages, and cash or a tax credit	.163*	.091	.205**	-.087	.034
Medical expenses, lost wages, and life-Long medical coverage	.081	-.122	.149*	.030	.005
Medical expenses, lost wages, life-long medical coverage, and a lump-sum cash payout	-.013	.093	.193*	.102	.048
No limits to compensation	.083	.064	.118	-.004	.044

*Other healthcare professionals (n = 10)
** p <.01, 1-tail test
* p <.05, 1-tail test

particular, there is little difference in support between nurses (4.60) and social workers (4.69). Both groups also support a federal tax deduction (3.29 and 3.45). Neither group agrees that donors should receive a cash payout of $60,000 to $70,000 or freely negotiate a level of compensation without limitations, with virtually no difference between nurses and social workers on these items (1.99 and 2.01 and 1.75 and 1.77, respectively). Interestingly, nurses and social workers are more divided on non-compensated altruistic giving than on several other items, with nurses expressing more agreement with altruism than social workers (3.76 to 3.57).

As illustrated in Table 6, a statistical examination of the relationships between the statements comprising the social distance scale and the ethical-motivation scale revealed statistically significant positive correlations between willingness to donate a kidney to close or distant others and certain material rewards (p >.01 1-tail test and p >.05 1-tail test). These positive correlations are most striking for willingness to donate to a close friend and include a variety of different reward packages. Also positive was the relationship between: 1) willingness to donate to an immediate family member and a monetary reward in the form of paid medical expenses, lost wages, and a tax credit, and 2) willingness to donate to an acquaintance and a tax credit and a compensation package involving medical expenses, lost wages, and a weekend getaway. There were no other statistically significant positive or negative correlations.

To assess the amount of compassion fatigue among social workers and nurses as it relates to motivation to becoming a living kidney donor, we used an 11-item summated rating compassion fatigue scale. Table 7 illustrates means and standard deviations for all 11 items. Overall, the results suggest that social workers and nurses experience a low to moderate amount of compassion fatigue. Both nurses and social workers agreed that they bring work home with them (2.91 and 3.19) and feel physically and emotionally exhausted by the end of the work day (3.01 and 3.06). However, less agreement was expressed for the feeling that work dominates their lives (2.88 and 2.78) or that their work goes unappreciated or unrecognized (2.34 and 2.48). Neither group agreed that they feel so burned out that they need to change or seek help to cope (1.56 and 1.52) or that they resort to drugs, drinking, gambling or other methods of escape as a function of their work lives (1.55 and 1.56).

DISCUSSION

To assess the persuasiveness of the NKF's altruistic "gift of life" frame among member nurses and social workers, this research utilized a research design developed by Humphries et al. (2009) and supplemented this design with a measure of compassion fatigue and work-related burnout. Results from the use of the Bogardus Social Distance Scale (Bogardus 1925; 1933) confirm, consistent with prior research (Humphries et al., 2009; 2014), that respondents are more willing to donate a kidney to a close other (e.g., a member of their immediate family) than to a distant other (e.g., a stranger). Thus, this research, considered in conjunction with prior research, provides strong empirical evidence that, regardless of target population, social distance is the single most important motivating factor in altruistic living kidney donation.

Additionally, a comparison of nurses and social workers using the Bogardus Social Distance Scale (Bogardus 1925; 1933) reveals that nurses are less willing than social workers

to participate in a living kidney donation. For nurses, these findings are consistent with earlier research (Humphries et al., 2014) and support the hypothesis that nurses are "pragmatic" in their orientation, as pointed out by Chambliss (1996). In contrast, the greater willingness among social workers to donate a kidney supports the hypothesis of an "idealistic" orientation.

However, on the ethical-motivation scale item that suggests donating a live kidney should be a "free-will donation and purely altruistic," nurses express somewhat more agreement than social workers. This is in sharp contrast to Humphries et al. (2014), which finds low support for altruism among a sample of international nurses and high support for "no limitations" on donor compensation and direct cash payouts of $60,000–$70,000. On the assumption that nurses would show strong support for high-value incentives as indicated by Humphries et al. (2014) and that this might be explained by work-related factors, we included in the present study a compassion fatigue scale, but the results from the prior study were not replicated. In the present study, both nurses and social workers expressed low support for cash payouts and other high-value rewards. Furthermore, on the compassion fatigue scale, both nurses and social workers reported that while they "feel physically and emotionally exhausted at the end of the work day," they found work personally rewarding and were not "burned out." In the absence of significant differences in compassion fatigue, a possible explanation for the difference between the nurses in the current study and those in Humphries et al. (2014), is that the latter included professionals not necessarily affiliated with nephrology or the NKF, which regards financial compensation for organs as unethical (NKF, 2003). Compassion fatigue also does not appear to explain the greater social distance expressed by the current sample of nurses in that the results on the compassion fatigue scale are comparable for both nurses and social workers. This may be due to cultural rather than structural factors, such as the different professional worldviews and socialization experiences of nurses and social workers.

Despite lack of support for high-value material rewards, results from the ethical-motivation scale show strong support among both nurses and social workers for limited material incentives in the form of compensation for medical expenses, lost wages, and a federal tax deduction. This is consistent with prior research involving college students

Table 7. Means and Standard Deviations for Compassion Fatigue (N = 159)

		Nurses (n = 68)	Social Workers (n = 91)
Work dominates life	*Mean*	2.88	2.78
	SD	1.25	1.15
Rely on my co-workers for advice	*Mean*	2.55	2.68
	SD	1.07	1.06
Emotionally detached in my professional and personal life	*Mean*	1.94	1.87
	SD	0.94	1.02
Frequently taking work home with me	*Mean*	2.91	3.19
	SD	1.30	4.55
Working harder and accomplishing less	*Mean*	2.62	2.76
	SD	1.08	1.10
Physically and emotionally exhausted by end of the work day	*Mean*	3.01	3.06
	SD	1.49	1.18
Resort to drinking, drugs, gambling, or others methods of escape	*Mean*	1.55	1.56
	SD	0.93	0.94
Question competence and effectiveness of my work performance	*Mean*	2.45	2.29
	SD	1.18	1.13
Work goes unappreciated and unrecognized	*Mean*	2.34	2.48
	SD	1.05	1.17
Difficult to form meaningful relationships outside the workplace	*Mean*	1.86	1.73
	SD	0.78	0.99
Feel burned out and may need change or help	*Mean*	1.56	1.52
	SD	0.70	0.84

SD = standard deviation

(Humphries et al., 2009) and is relevant to how we "frame" living kidney donation. Our findings suggest that the "gift of life" frame is not persuasive when it comes to motivating individuals to undergo a live kidney donation, particularly when it involves an unrelated other. Specifically, the results show that unless the recipient has a close relationship to the donor, there is a low willingness to donate. Given this, we find merit in the argument of Humphries et al. (2014) in favor of re-framing living donation to emphasize both justice and rights. Specifically, these authors argue that material compensation could be construed as a *just reward* that preserves the rights of a selfless donor to autonomy, integrity, and dignity. In our view, this *restorative* frame avoids the perception of "cash for organs" that lacked resonance with the nurses and social workers in this study.

Importantly, this research suggests that any changes to organ donation policy should consider changing the message in addition to the rules. Due to their professional socialization and knowledge of altruism, social justice, and patient rights, nurses and social workers can help, through interdisciplinary and theoretically informed analyses, to reframe health-related issues in ways that better address the persistent organ shortage. Thus, these professionals are valuable allies in the task of policy development as it pertains to the question of donor compensation.

LIMITATIONS OF THE STUDY

This study replicates research by Humphries et al. (2009; 2014), and therefore shares the same shortcomings. These include a small, non-representative sample and the use of indicator variables that do not measure actual behavior (Meyers, 1999). Given the high human cost of the ongoing organ shortage as well as the growing interest in the medical community in material incentives as a complement to donation, we believe these limitations are acceptable and join the call for additional research that can further inform the changing debate (Salomon et al., 2015).

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