

Gift exchange and organ donation: Donor and recipient experiences of live related kidney transplantation

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Abstract

Background: Live transplantation presents many stressors for donors and recipients, yet a holistic understanding of the process, from both perspectives, is limited. Gift exchange is a theory governed by the principles of giving, receiving and reciprocating and has many similarities with the process of organ transplantation. It may therefore provide a framework for understanding donor and recipient experiences of live kidney transplantation. However, the relevance of this theory to live kidney transplantation has not previously been properly explored.

Objectives: To gain a theoretical understanding of the live transplantation experience from the perspectives of donors and recipients.

Design: A phenomenological, longitudinal study.

Participants: All donors and their recipients undergoing live kidney transplantation in a regional renal transplant centre in South-West England (between July 2003 and February 2004) were invited to participate in this study. Of this cohort, 11 families ($n = 55%$) volunteered to participate.

Methods: Data were collected through a series of 3 recorded, semi-structured interviews with donors and recipients. Interviews were conducted pre transplant and at 3 and 10 months post transplant. Data were analysed using a process of thematic content analysis. Findings were also considered within a theoretical framework of gift exchange.

Results: All donors initially made an instantaneous, voluntary decision to donate and found the decision relatively easy to make. In contrast, recipients found accepting the donors' offer arduous, because of concern for their wellbeing. They were only able to accept the transplant after discussing the matter with their donor and establishing that it was something that they wanted to do. Recipients' lives were transformed by a successful transplant and they were subsequently very grateful to the donors for donating. Donors derived immense personal satisfaction from this outcome and it helped to confirm to them that what they had done had been worthwhile. The transplant did not have a detrimental effect on donor–recipient relationships.

Conclusions: The concept of gift exchange provides a logical explanation of donor and recipients experiences in this study, particularly in relation to factors that influence giving, receiving and reciprocating. This understanding should help health professionals assist donors, recipients and their families throughout this process.

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Keywords: Donors; Gift exchange; Live kidney transplantation; Organ donation; Recipients; Transplants

What is already known about the topic?

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- Rates of live kidney transplantation are increasing. However, the process places many potential demands on

- donors and recipients, particularly in relation to donating and receiving a kidney.
- The theory of gift exchange is a form of contract governed by three major principles; giving, receiving and reciprocating.
 - It has been suggested that gift exchange has many similarities with the process of organ transplantation and may, therefore, offer a theoretical framework for understanding the transplantation process.

What this paper adds

- Donating a kidney is intrinsically rewarding for donors. The ‘joy of giving’ is a significant non-material form of reciprocation for donors and helps to confirm to them that what they did was worthwhile.
- Recipients find accepting the offer of a kidney transplant onerous, primarily because of concern for the donor. Consequently, where appropriate, donors should be encouraged to speak to their recipient about donation, as it could help to facilitate their decision-making process.
- Live kidney transplantation has the essential features of a contemporary gift. Evidence from this study suggests that gift exchange theory provides an appropriate framework for understanding the live transplantation process, particularly factors that influence giving, receiving and reciprocating.

1. Introduction

It has frequently been suggested that organ transplantation, particularly in Western societies where the donation system is based on the principle of voluntary altruism, may be analogous with the process of gift exchange. Indeed, ‘the gift of life’ metaphor has traditionally permeated organ transplantation campaigns, primarily because the apparently selfless act of donation by one individual could transform and even save the life of another who is seriously ill. When the focus is on the donated organ itself, the intended sense of ‘gift’ is much easier to identify with, as the organ is being given to someone in a similar way in which a present would be (Gerrand, 1994).

Mauss (1990) proposes that gifting is a form of contract governed by three major concepts: the obligation to give, receive and repay. In terms of an exchange model, organ transplantation (particularly live transplantation) is, arguably, psychosocially similar to the dynamics of gift exchange as the process also involves giving, receiving and reciprocating (Fox and Swazey, 2002). Consequently, it has been postulated that gift exchange theory may provide health professionals with a useful framework to better comprehend the organ transplantation process. For example, it could help to highlight the strains and stresses that donors, recipients and their families often experience pre and post transplant, associated with issues such as decision-making and the potential pressures associated with giving, receiving and

reciprocating (Sque and Payne, 1994; Conrad and Murray, 1999). Therefore, this framework, if appropriate, could inform practice, education and research strategies to help ensure that health professionals are better equipped to support those involved in the process and facilitate decision-making at such a complex time (Sque and Payne, 1994).

However, despite the considerable number of publications relating to gifting and organ transplantation, the potential relevance of this framework to this process has received little empirical evaluation. Many academics merely refer to the theory somewhat naively, often with little or no critical thought concerning whether the framework is actually useful or even relevant in this context. This qualitative, longitudinal study was therefore undertaken to explore donor and recipient experiences of live kidney transplantation and to critically assess the potential relevance and usefulness of the gift exchange theory to the live transplantation process.

2. Literature review

2.1. The gift

The theory of ‘gift exchange’ was developed in the 1920s by Marcel Mauss. In the early 1900s, Mauss (1990) discovered that some small, non-industrialised societies in the Pacific Islands and along the North-West coast of America lacked properly developed market-based economies with which to trade. Therefore, the primary system of exchange in these societies, although not totally devoid of market principles, largely took place in the form of gifts (Levi-Strauss, 1967).

Mauss (1990) surmised that, despite the façade that gifts are voluntary, they are, in fact, obligatory and governed by the concepts of giving, receiving and reciprocating. Giving is seen to create a sense of ‘indebtedness’ in the receiver. The person who receives the gift is therefore obliged to reciprocate, occasionally with interest, the present received. Failure to do so will result in the receiver being considered ungrateful and even inferior (Mauss, 1990).

Gift exchange has two important functions. First, it is a simple, effective way of exchanging goods in the absence of money. Second, and perhaps more importantly, it is an effective way of establishing and sustaining mutually desirable relationships. Mauss (1990) maintains that giving, receiving and reciprocating are obligatory but, in reality, the process is probably driven by various factors such as duty, obligation, honour, respect and, particularly, although perhaps unknowingly, self-interest (e.g., to improve one’s social standing) (Strathern, 1992).

Gifting is, by its very nature, highly personalised. Consequently, gifts are often personally significant to both giver and receiver and are therefore perceived to carry ‘identity’. Mauss (1990) refers to this phenomenon as ‘the spirit of the gift’, whereby the gift carries with it the ‘spirit’ of the giver. Through ‘the spirit of the gift’, the giver has a hold over the

beneficiary and this, it is believed, also reinforces the cycle of exchange (Sque and Payne, 1994).

2.2. *Gifting and the human body*

Gift theory provides a framework for understanding gifting behaviour in contemporary society, but unlike in Mauss's day, gifting is now rarely obligatory. The concept of gifting has also been linked to processes far more complex than the exchange of inanimate objects originally described by Mauss (1990). For example, organ donation in particular has often been described by health professionals as 'the gift of life', probably for several reasons. First, the metaphor easily conveys to the public the good that comes from transplantation, whilst also maintaining respect for donors, and the need to increase rates of transplantation (Gerrand, 1994). Second, it directly reflects the principles of voluntary altruism on which the donation system is based (Gerrand, 1994). Finally, the strategic use of the metaphor by health professionals is seen as a way of ensuring that recipients are appreciative of their transplants and are therefore more likely to take care of their general health post-operatively (Siminoff and Chillag, 1999).

While cadaveric donor families usually consent to donation because they want to (rather than because they feel obliged to), prospective recipients are often under some pressure to accept an organ once offered, since refusal could result in deteriorating health and even death (Fox and Swazey, 2002). Furthermore, when successfully transplanted, an organ may actually save the recipient's life or, at the very least, transform it, so the 'gift' in transplantation is not merely the organ, but also 'life' itself (Deguchi, 2002). Consequently, transplantation often sets up feelings of identification, indebtedness and responsibility in recipients (Fox and Swazey, 2002). Therefore, as in traditional gift exchange, many recipients want to somehow reciprocate the 'gift' they have received. Such psychosocial obligations can be onerous, though, because 'the gift of life' is of such extraordinary magnitude that it is inherently beyond reciprocation, particularly in an economic sense, since financial reimbursement for human organs is outlawed in developed countries (Sque and Payne, 1994; Siminoff and Chillag, 1999). Fox and Swazey (2002) refer to this phenomenon as the 'tyranny of the gift'.

However, the inability to properly reciprocate does not eliminate the impulse to attempt to repay. Just what constitutes appropriate reciprocation in these circumstances is debatable but many recipients send anonymous letters of thanks to donor families through health professionals, in an attempt to deal with their sense of obligation and most find this extremely satisfying (Siminoff and Chillag, 1999). Evidence also suggests that donor families greatly value such gestures, as it often helps them to come to terms with their loss (Bartucci and Seller, 1988; Clayville, 1999).

2.3. *Cadaveric transplantation: is it really analogous with gifting?*

Whilst there are many similarities between cadaveric transplantation and gifting, there are also some fundamental differences, such as the lack of freedom associated with giving and receiving, due to 'gatekeeping' factors in the procurement process (Conrad and Murray, 1999; Vernale and Packard, 1990). That is, a person cannot choose who to give an organ to, as various health professionals (i.e. 'gatekeepers') manage the donation process, establishing who can and cannot donate and to whom organs are given.

Also for a gift to truly be a gift, it has to be the givers to give. Yet in cadaveric donation, it is the donors' families who consent to giving and not the donors, even if they carried a donor card, because the donor is dead. Organ recipients cannot, therefore, personally express gratitude to the donors, or even their families because current procurement procedures ensure that they remain anonymous. Finally, the donation cannot be the basis for any relationship between the two parties, as it can only take place because the donor has died (Gerrand, 1994). Therefore, despite apparent similarities between gifting and the act of cadaveric donation, these significant differences suggest that cadaveric transplants cannot constitute a 'true Maussian gift'.

2.4. *Gifting and live related transplantation*

Gift theory has rarely been considered from the perspective of live related transplantation, yet there is a greater degree of similarity between live transplantation and gifting than between cadaveric donation and gifting (Gerrand, 1994). In live donation, the kidney 'belongs' to the donor, and is, therefore, theirs to give away if they so wish. Unlike in cadaveric donation, there is also a pre-existing relationship between donor and recipient. Therefore, providing the organ is given and received unconditionally, without coercion, the act of live related donation does seem to be analogous to gift giving because the giver wants to benefit the recipient, has acted freely and nothing is expected in return (Gerrand, 1994).

2.5. *Live kidney transplantation*

In the UK, there are currently 7592 people on the active transplant waiting list, 6713 of whom are waiting for kidney transplants (UK Transplant, 2008a), a figure that rises annually. Although cadaveric donors provide the majority of human transplantable organs, over one in four kidneys in the UK are now provided by live donors. Compared with cadaveric transplants, live kidney transplants offer many potential benefits, including improved patient and graft survival rates (BTS/RA, 2000; UK Transplant, 2008b). Consequently, rates of live kidney transplants are likely to increase significantly over the next several years.

However, as the number of live kidney transplants increases, so does the need to explore and better understand the experiences of donors and recipients to help guide the provision of care, information, advice and support (Olbrisch et al., 2001; The Amsterdam Forum, 2004). Most relevant studies in this area have predominantly explored the experiences of live kidney donors (e.g., their decision-making process) and occasionally their families (Simmons et al., 1987; Karrfelt et al., 1998; Stothers et al., 2005) and donors' feelings about donating and/or quality of life issues post transplant (Jacobs et al., 1998; Johnson et al., 1999; Fehrman-Ekholm et al., 2000; Schweitzer et al., 2003). An extensive literature search (using CINHALL and MEDLINE) revealed that recipients' experiences of live transplantation (and/or the combined experiences of donors and recipients) have been subject to very little research. Furthermore, most related published studies are retrospective and, consequently, have failed to adequately illuminate the experiences of patients as they progress through the initial transplantation process.

There is, therefore, a need for further research in this area that increases understanding of donor and recipient experiences, but also informs the understanding of those experiences.

2.6. The need for further research

Although the label of gift has been frequently applied to organ transplantation, the concept is usually referred to in an uncritical manner and has rarely been conceptualised by health professionals in a way that yields insights into its broader medical and psychosocial significance (Fox and Swazey, 2002). This study was therefore undertaken to establish if gift exchange theory is applicable in the context of live kidney transplantation and, if so, what is the usefulness of this framework to health professionals.

3. Methods

The aim of this research was to provide an in-depth exploration of participants' experiences of live kidney transplantation. Consequently, a qualitative, phenomenological approach, informed by the philosophy of Heideggerian hermeneutics, was used to conduct this study (Heidegger, 1962; Walters, 1995). Phenomenology is a research/philosophical approach used to understand the lived experiences of participants (Crotty, 1996). It is an inductive, descriptive method that attempts to study phenomena, as they are consciously experienced (Beck, 1994).

The focus of Heideggerian hermeneutics is the 'interpretation' of 'lived experiences'. Researchers subscribing to Heideggerian philosophy acknowledge that they can only interpret something according to their own beliefs, experiences and preconceptions, which are a legitimate part of the research process and should not be left out (Lowes and

Prowse, 2001). Therefore, researchers using this approach acknowledge their own background and preconceptions and use them constructively to 'co-create data' with their participants in data collection and analysis phases.

3.1. Aims

The objectives of this study were to explore:

- The experiences of donors and recipients throughout the live transplantation process.
- The relevance of the theory of 'gift exchange' as a framework for exploring and understanding donor and recipient experiences of live transplantation.

3.2. Sample and recruitment

Participants were recruited between July 2003 and February 2004 from a regional renal transplant centre in South-West England. All families undergoing live transplantation during this period ($n = 20$) were sent a letter and information leaflet, outlining the purpose and nature of the study by the unit's live transplant co-ordinator. Respondents wishing to participate in the study contacted her to express an interest. Families were then contacted by the researcher (PG), who was not involved in their care, to arrange a mutually convenient meeting to conduct the interviews. In total, 11 families (55%) consented to participate in the study. The sample group therefore comprised 22 participants: 11 donors (6 females, 5 males) and 11 respective recipients (6 males, 5 females). Donors' mean age was 50 years (age range 36–62 years) and recipients', 46 years (age range 32–63 years). Demographic details are provided in Table 1:

3.3. Data collection

Data were collected through a series of three, recorded semi-structured interviews, conducted pre transplant and three and ten months post transplant. All participants were interviewed separately, in private, in their own homes. The aim of the phenomenological interview is to be open to the

Table 1
Participant information

Family	Donor	Recipient
1	Husband	Wife
2	Husband	Wife
3	Husband	Wife
4	Brother	Sister
5	Wife	Husband
6	Wife	Husband
7	Wife	Husband
8	Mother	Daughter
9	Wife	Husband
10	Wife	Husband
11	Father	Son

participants' own experiences and allow them to tell their story in their own words (Kvale, 1996). The interview schedule therefore consisted of topic themes that helped inform the interview and explored participants' experiences of the transplantation process, pre and post transplant.

Initial interview questions explored participants' experiences of discovering that a renal transplant was required and the impact of transplantation on donor–recipient relationships. For example, 'can you tell me about your experience since you discovered that you/your [spouse/relative] needed a kidney transplant'? Follow up interviews focused on post transplant experiences and the impact of transplantation on donor–recipient relationships. The interview schedule was piloted, at all stages of data collection, on the first two families recruited into the study. However, all of the interview schedules were found to be satisfactory and were not amended in any way.

3.4. Rigour

Rigour, or trustworthiness, is an essential element of any research endeavour to help ensure that research findings are credible and valid (Holloway and Wheeler, 2002). In the current study, the use of an 'audit trail' assured transparency (Koch, 1996). Clarification of methodological decisions, and researcher self-awareness and reflection, allows the reader to follow the researcher's decision trail and assess for trustworthiness. At the time of the study, PG was a critical care nurse with an interest in organ transplantation and an academic background in nursing and social anthropology. Pre-conceptions, background understanding and values were acknowledged and reflected upon throughout the study. Analysis of the data was reviewed with the other author (LL).

3.5. Data analysis

Interviews were transcribed verbatim and analysed using a process of thematic content analysis recommended by Burnard (1991). This involved reading and re-reading interview transcripts to identify and develop themes and categories that emerged from the data. A working list of coding categories was developed by continually repeating this process up to and until all transcripts were collated. Transcripts were then re-read alongside the list of categories to establish the degree to which the categories covered all aspects of the interviews (Burnard, 1991). This process can help ensure that premature inferential leaps are not made and allows refinement and adjustment of coding categories (Mays and Pope, 1995). The constant search for understanding and meaning of the data, by continually moving between parts and the whole of the text being analysed, is also an essential element of the 'hermeneutic circle' (Polit and Beck, 2005).

All interview transcripts were constructively explored with LL to discuss emerging themes, theories and categories. It has been argued that involving an additional experienced qualitative researcher may help guard against potential lone

researcher bias and provide additional insights into theme and theory development (Cutcliffe and McKenna, 1999; Barbour, 2001). The purpose of these sessions, however, was not to seek concordance of opinions regarding thematic generation, but to constructively extend interpretation of the data and emerging themes.

Four central themes identified were (1) The decision-making process, (2) The transplantation process, (3) The emotional impact of transplantation and (4) Post transplant relationships. Where appropriate, verbatim participant quotes have been selectively used to illustrate key elements of these themes. Due to space constraints, extracts have been chosen that concisely convey the issues raised and do not, therefore, reflect any corresponding data bias.

3.6. Ethics

Local Research Ethics Committee (LREC) approval was granted in May 2003. Written informed consent was obtained from all participants before the first interview and verbal consent before all subsequent interviews. Respondents were assured of anonymity and confidentiality and advised that they could stop the interviews or withdraw from the study at any time. To ensure participant anonymity and confidentiality, names have been replaced by an identification code, according to the order in which respondents were originally recruited into the study, e.g., D1, husband (donor 1, husband of the recipient) and R4, sister (recipient 4, sister of the donor).

4. Findings

4.1. The decision-making process

Donors' decision-making process was relatively straightforward. All initially made an instantaneous, voluntary decision to donate (they were not asked to do so), with little or no deliberation and experienced no pressure from others to do so. Donors maintained that the decision to donate was rational and informed and no one regarded this decision as 'brave or heroic'; all felt that it was just a 'natural thing to do'. The only variation in this process was found in brother to sister donation (F4). This donor (D4) also initially made a straightforward decision to donate but subsequently spent several months contemplating his decision. Although he could not provide a definitive rationale for his indecision, he too eventually decided that he genuinely wanted to proceed with the transplant. No donors regretted making the decision to donate.

The primary reason for donating a kidney was to help restore the health and wellbeing of the recipient:

"It's just something that I can do. I can give my daughter a kidney and a new lease of life. I should imagine anybody would want to do that" (D8, Mother 1st interview).

The other main reason for donating, in spousal donors only, was to help restore their life together as a couple:

“If she is in poor health we won’t be able to do things that we want to do. I suppose you could regard it as selfish, but if I can help her from being ill, so that we can continue doing what we like doing, well that’s practical” (D3, husband, 1st interview).

Kidney transplantation (and live transplantation in particular, due to improved graft survival rates) was the treatment of choice for all recipients, as it was perceived to offer the greatest prospect of improved health and a return to ‘normality’, which would benefit them and their families. However, while appreciative of the donors’ offer to donate, most recipients were reluctant to accept this offer out of concern for the donors’ health and wellbeing. Recipients were only able to accept the donors’ offer of a transplant after discussing the matter with them and establishing that it was something they really wanted to do:

“When my wife offered to give me her kidney, it’s not that you’re ungrateful but I didn’t want her to go through that for me. But we talked it over and eventually decided that it was the best way forward and reluctantly, but gratefully, I’ve accepted it” (R7, husband, 1st interview).

Recipients emphasised that they had not asked the donor to donate (it was a decision that all donors had made for themselves), as they felt it would be like ‘begging’, would potentially leave them feeling ‘beholden’ and would put unnecessary pressure on the donors. Recipients also stressed that they would not want to accept a kidney given ‘with strings’ as this would leave them feeling unduly ‘beholden’ to the donors.

4.2. The transplantation process

The transplantation process was relatively uneventful for most participants, although many experienced some minor post-operative complications, such as pain, nausea and vomiting and wound problems (e.g., retained sutures). One donor (D11) experienced a post-operative bleed that required a laparotomy to repair a bleeding blood vessel and a blood transfusion. Most recipients experienced episodes of acute graft rejection, although all were successfully treated. However, one recipient (R3) experienced irreversible graft failure, several days post transplant, which did not respond to aggressive treatment. The impact of this for her and her husband was profound and, consequently, will be discussed in a separate publication. All donors generally made a good recovery post transplant and most were back in work within 12 weeks and generally considered themselves ‘back to normal’ after 10 months.

The impact on the recipients’ health was profound. Recipients’ lives were simply transformed by the transplant and they were subsequently able to do things that they had not been able to do in years, such as exercising. Those who were working pre transplant were able to return to work after several months and many had been on holidays, some

abroad, for the first time in years. Most were now also making medium to long term plans for the future, which they had previously felt apprehensive about. This obviously had a significant impact on their lives and that of their families:

“I can’t believe the difference it’s made, I haven’t felt so well in about 5 years. Now I can take an interest in what my kids are doing, whereas before I just didn’t have the energy. I think it’s a miracle and I’m back to sport now. I’m doing yoga and running. I’m thinking of running a 5k soon and maybe even a half marathon eventually with my brother. It’s just nice to be able to sit in the garden and enjoy it without going straight to bed. I’m getting back to normal now, back to the independent person that I was before” (R4, sister, 2nd interview).

4.3. The emotional impact of transplantation

Recipients were delighted with how their lives had improved since the transplant and were extremely grateful to the donors for donating. However, whilst all had thanked their donor for donating, many found it difficult to articulate just how they felt:

“I’m very appreciative and grateful but it’s very difficult to just say ‘oh thanks for that’. It’s quite meaningless when you put it against what she actually did. I know she knows what I feel but it’s quite difficult to put it into words because there are no words really that you can express what you feel about it” (R8, daughter, 2nd interview).

Conversely, donors were delighted with how the transplant had improved the lives of the recipients and their families, and all subsequently derived immense personal satisfaction from having donated. For many donors, this helped confirm to them that what they had done had been worthwhile:

“I feel very proud to have donated to my sister and the whole experience has been very positive for all of us. When I see her I feel really proud about what I’ve done, it’s like an amazing experience. You feel you’ve done something really worthwhile in your life. I feel like it’s maximum gains for my sister, her family and me because the way it’s made me feel with relatively little cost” (D4, brother, 2nd interview).

4.4. Post-transplant relationships

Although some participants felt that their relationships with each other had improved since transplantation, most felt that their relationships were the same and certainly none had deteriorated in any way. Nonetheless, due to the impact of transplantation, and particularly recipients’ associated sense of gratitude, many believed there was a potential for the transplant to alter the tenor of their relationships with each other, although no one felt that it actually had. However, both donors and recipients helped

to ensure that their relationships with each did not change as a consequence of the transplant, by the way in which they behaved with each other, particularly the way in which donors behaved with the recipients before and especially after transplantation:

“Some donors shrug it off, maybe that’s how they feel, but I think it’s an incredible thing to do. My brother’s attitude has really helped me, because he hasn’t made me feel guilty. He’s very humble and unassuming. You can’t thank someone enough, but there’s no obligation from him, no pressure like, ‘look what I’ve done for you’. He’s just pleased for me and that’s great, because I think, Christ he did that for me.

I think maybe there is a potential for me and others to feel beholden to the donors for what they’ve done. But I think it’s the donor’s attitude and the way they behave with you after the transplant that allows you to get on with your life without feeling indebted to them. I think because most donors don’t feel that what they have done is particularly brave or heroic, and they don’t expect us to feel beholden to them, allows us to move on without feeling awkward or feeling that you owe them something for the brilliant thing that they’ve done for you” (R4, sister, final interview).

Donors tended to downplay their actions and emphasised that they did not expect anything in return from the recipients. Also, despite the way in which donors and recipients now felt about the transplant and how it had affected their lives, after 10 months particularly, they tended not to have any profound discussions about it. This was due to participants feeling that transplantation had consumed much of their lives recently and amongst donors especially, there was a belief that everyone, particularly the recipients, now needed to ‘move on with their lives’:

“I think it’s best not to keep talking about it because it’s over and done with. It’s something that we’ve done, it’s benefited both of us, so why go on about it? I think it’s important that you get back to normal really. Also, I think it’s important for him, he doesn’t want to keep being reminded of it. You wouldn’t want him to feel that he’s beholden in any way. So I think that you wouldn’t want to keep bringing it up in conversation. I think it’s time to move on” (D7, wife, final interview).

5. Discussion

To properly assess whether a live kidney transplant constitutes a ‘gift’ in the Maussian sense, it is first necessary to explore the circumstances in which giving (i.e. donating), receiving and reciprocating occurs. The longitudinal design of this study allowed exploration of data at three key stages of the transplantation process to determine whether participants’ experiences changed over time in relation to these theoretical principles.

5.1. Giving (donating)

Research has characterised live donors’ decision-making into 3 patterns; straightforward (instantaneous with little or no deliberation), deliberative (a period of deliberation before a conscious decision is made) and postponement (no real decision made, decision made for them not by them) (Simmons et al., 1987). Multiple studies have shown that most donors make a straightforward decision to donate and, as in this study, are happy to have donated and have no regrets about doing so (Simmons et al., 1987; Johnson et al., 1999; Fehrman-Ekholm et al., 2000; Schweitzer et al., 2003; Stothers et al., 2005). Crouch and Elliott (1999) maintain that such moral and emotional commitments are not exceptional or constraints of freedom but rather are a part of ordinary family life.

Despite the relative ease with which most donors decide to donate, though, up to 25% of prospective donors deliberate over their decision and up to 5% postpone decision making completely (Simmons et al., 1987; Stothers et al., 2005). In this study, there was only one instance of deliberative decision-making in a brother to sister donation, although the definitive reason for this is unclear. It is suggested that deliberation is more likely to occur the more distant the relationship between donor and recipient, as the desire and motivation to donate may be weaker (Olbrisch et al., 2001). Nonetheless, with time and support, most donors eventually make a decision that they are happy with (Schweitzer et al., 2003). It is imperative that health professionals develop effective strategies to identify and address any concerns donors have about donating, ensure they are properly prepared and informed for transplantation and given sufficient time and support to make their decisions.

Reasons for donating can also help to determine if a live transplant could be perceived as a ‘gift’. For example, in this study, there were no instances of ‘conditional giving’ (e.g., to gain emotional control over the recipient). Gift giving is thought to involve some degree of generosity and is commonly undertaken to benefit the recipient, without valuable consideration or explicit expectations of recompense. Therefore, if a kidney was donated ‘with strings’, it is doubtful whether it would be regarded as a gift by either party (Gerrand, 1994). Furthermore, no donors donated because they felt obliged to. Feeling obliged or compelled to donate would, perhaps, indicate an element of coercion and giving in such circumstances would probably not only affect the donor’s ability to provide informed consent but would also not be sufficiently voluntary to be called a gift (Godbout and Caille, 2000).

Data show that donors, much like contemporary gift givers, donate because they want to and, as other studies have shown, typically do so for altruistic reasons; i.e., to help restore the health of a loved one (Hilton and Starzomski, 1994; Eggeling, 1999, 2000). But whether true altruism (i.e., genuine selflessness) exists is questionable, since people often have egoistic reasons for being altruistic (Rapport and

Maggs, 2002). For example, in the spousal donors especially, donation appeared to be motivated by a tacit amalgam of altruism and self interest, as donation provided them with an opportunity to restore the recipient's health and therefore also their family life. It would, perhaps, appear that live transplantation, like personal gifts, can benefit the other and the self (Murray, 1987), but they rarely cause problems, since they are mutually beneficial to donors and recipients:

'Altruistic gestures toward others are invariably tempered by the after effect of realising that one's own self interest must be bound up somewhere, if only in maintaining one's social environment' (Strathern, 1992, p. 130).

5.2. Receiving

The data strongly suggest that recipients' decision-making process (i.e., why and how they decide to accept the offer of a transplant) was far more complex and arduous than that of donors. While prospective recipients generally view renal transplantation as the best treatment option, many find the offer of donation emotionally burdensome, out of concern for donors' health and wellbeing (Hilton and Starzomski, 1994; Murray and Conrad, 1999; Franklin and Crombie, 2003; Schweitzer et al., 2003). Such concerns, if not addressed, could be a significant obstacle to improving rates of live transplantation.

Consequently, where appropriate, donors should be encouraged to reassure their recipient that they genuinely want to proceed with transplantation, providing this is the case, to facilitate their decision-making. Health professionals need to recognise how difficult the decision to accept a transplant can be for recipients and provide appropriate care, information and support.

Recipients often completely reject offers of transplants from certain family members, e.g., children, because of insuperable concern for them. Also, as this study demonstrates, many do not want the responsibility of requesting a transplant, or accepting an offer of donation 'with strings', because they want to avoid feeling unduly indebted to the donor (Olbrisch et al., 2001), as the transplant would subsequently represent a 'gift' that could never be repaid. Besides, a gift that is given 'conditionally' is not really a gift at all and would probably not be viewed as such by either party. Health professionals need to be aware of the reasons why and how recipients make decisions about live transplants and from whom they will, and will not, accept an organ (Murray and Conrad, 1999).

Most recipients view the transplant experience positively and very few regret having a live transplant (Burroughs et al., 2003; Schweitzer et al., 2003). However, although the transplant rarely causes psychosocial problems, particularly between recipients and donors, the gift of an organ often creates feelings of identification, indebtedness and a special kind of responsibility in recipients (Fox and Swazey, 2002). Indeed, receiving an organ from a related donor appears to have all of the key features associated with contemporary

gifting, in that it involves a certain amount of implicit 'etiquette'.

For example, common implicit obligations of recipients could be described as 'grateful conduct' and 'grateful use' (Murray, 1987; Gerrand, 1994). This essentially means that the transplant is accepted with some expression of gratitude and, thereafter, the recipients are expected to 'look after' their transplanted kidney by taking care of their general health. In this study, recipients frequently expressed their gratitude to their donors for donating. However, given the nature of the 'gift', some recipients may find this expectation potentially overwhelming, particularly as failure to 'respect' the gift may have a detrimental effect on the recipient's health and also affect the donor's feelings.

5.3. Reciprocation

Whilst giving and receiving are irrefutable features of live transplantation, whether or not reciprocation occurs in a meaningful way that satisfies both giver and receiver is questionable. It has, of course, been argued that the problem of receiving a 'gift' such as a transplanted organ is that it is essentially unrequitable (Smith, 1998; Siminoff and Chillag, 1999; Fox and Swazey, 2002). Even if recipients were to attempt to reciprocate, what counter gift could adequately commensurate with what they have been given? Consequently, some recipients may feel unduly indebted to the donor and may, therefore, experience psychosocial problems, such as feelings of guilt, disequilibrium and relationship problems (Fox and Swazey, 2002; Crombie and Franklin, 2006). However, this and other studies have found that relationships between donors and recipients rarely deteriorate post transplant; in fact, they usually remain the same, or even improve (Higgerson and Bulechek, 1982; Simmons et al., 1987; Burroughs et al., 2003). Therefore, if live transplantation constitutes a gift in the Maussian sense, this would, perhaps, indicate that some form of meaningful reciprocation had occurred.

It has been postulated that recipients first attempt to deal with their sense of obligation by expressing gratitude to the donor, which may represent a non-material form of reciprocation (Vernale and Packard, 1990; Fox and Swazey, 2002). It seems that this is an important implicit expectation in live transplantation because, although donors may not expect the recipients to be obsequious towards them, when recipients do not express a reasonable amount of gratitude (although what constitutes 'reasonable' is unclear) donors often feel angry and used (Simmons et al., 1987; Schover et al., 1997).

But in and of itself, is the mere expression of gratitude a sufficient form of reciprocation? Findings from this study suggest that, whilst potentially important, showing some degree of appreciation is not the only, nor the most significant, form of non-material reciprocation. For example, the data show that donors were delighted with how recipients' lives had improved since transplantation and consequently derived an immense sense of personal satisfaction

from having donated. Yet, by the very nature of what has been given, donors clearly cannot receive the equivalence of what they have given. Similarly, the gift will never be reciprocated in an economic sense; there is no equivalence, nothing tangible is returned (Godbout and Caille, 2000). However, this ‘joy of giving’ is, arguably, the most significant form of non-material reciprocation for donors and helps confirm to them that what they did was worthwhile. Godbout and Caille (2000) state:

‘However unilateral this may appear, research indicates that the donors’ return is enormous, even if what is returned is implicit in the act itself and is not embodied in any specific object or service. Something which would be impossible since, in the material sense, neither one exists. Donors are often transformed by their donation. The unusual return doubtless explains why, despite its apparently unbalanced, un-reciprocal, ‘impulsive’ nature, the gift rarely causes problems between donors and recipients. On the contrary, it often draws them closer together’ (p. 90).

Multiple studies have shown that donation commonly has a positive, often profound, impact on most live donors, resulting in many feeling happy and proud to have donated (Higgerson and Bulechek, 1982; Simmons et al., 1987; Johnson et al., 1999; Fehrman-Ekholm et al., 2000; Burroughs et al., 2003; Stothers et al., 2005). European and American studies have also found that live donors commonly report increased feelings of self esteem and self worth post transplant and, subsequently, are found to have a better quality of life than the age and gender adjusted general population (Jacobs et al., 1998; Johnson et al., 1999; Fehrman-Ekholm et al., 2000; Schweitzer et al., 2003).

It would appear, therefore, that live transplantation is intrinsically rewarding for most donors. The evidence suggests that, besides other non-material returns from giving, such as the gratitude and appreciation it inspires, the return for most donors is contained in the act of giving itself and many are personally transformed by this. In live transplantation, the return, non-existent in other forms of circulation, is part and parcel of the act of giving; to give is to reciprocate (Godbout and Caille, 2000). Therefore, for live donors in this study, there was no material return from their actions of the kind to which Mauss (1990) refers, but there was a return and it was significant.

It would also appear that, despite the unreturnable nature of the ‘gift’, by donors downplaying their actions and minimising recipients’ desire to show gratitude, donor and recipient relationships are not harmed as a result of the transplant (Simmons et al., 1987; Burroughs et al., 2003). This is analogous to the ‘etiquette’ of contemporary gifting, whereby gift givers often try to lessen the value of their gift by saying things such as, ‘it’s nothing special’ (Murray, 1987). This behaviour helps ensure that recipients do not feel unduly indebted for the gift, but, particularly in live transplantation, may also indicate the importance of the relationship to the donor (Murray, 1987).

5.4. Differences in the process

Whilst the live transplantation process in this study has the essential features of gift exchange, by the very nature of what is given and received, the process is far more complex than the exchange of material gifts originally described by Mauss (1990). Consequently, there are some fundamental differences in the legitimate exchange of live human organs and the exchange of inanimate gifts.

One key difference relates to the lack of freedom of giving and receiving associated with ‘gatekeeping’ issues. Therefore, even in live transplantation, no one is ever totally free to give or receive human organs. Live transplantation is also generally voluntary, not obligatory, although, as discussed, certain implicit obligations do appear to exist. Where donors, or recipients, feel ‘obliged’ to give or receive, it is questionable whether the transplant would be viewed as a gift by either party, as a gift that is imposed is not really a gift.

The potential relevance of gift exchange theory to the live transplantation process may be significantly related to various factors, particularly the motivations for giving and receiving and the relationship between donors and recipients. In this study, all donors and recipients had very good, pre-existing relationships with each other. However, where the relationship between the two is problematic or if transplantation occurs where the donor has given ‘conditionally’ or where the recipient has extorted a kidney from the donor, it is unlikely that the transplant would constitute a gift. The impact of the ‘gift’ is also probably dependent on the success of the transplant. For example, when the transplant is unsuccessful, the donor and recipient may experience great difficulty in making sense of the exchange (Franklin and Crombie, 2003). If the transplant fails, the recipient’s life will clearly not be transformed in the same way as it would have if the transplant had been successful and, therefore, the ‘joy of giving’ will probably not be as apparent, as was the case with the family affected by transplant failure in this study.

5.5. Implications for clinical practice and related research

Based on the evidence described in this paper, in terms of an exchange model, it would appear that live related transplantation has all the essential psychosocial dynamics of contemporary gifting. It is suggested, therefore, that the concept of gift exchange does provide a useful framework for understanding the live transplantation process, which could inform the development of clinical practice. In particular, it could provide an insight into factors that influence giving, receiving, reciprocating and associated issues. For example, it could assist health professionals to understand and predict the expectations and stresses that accompany the decisions of donors and their desire to give and recipients in their desire to receive and repay (Sque and Payne, 1994). It may, therefore, assist health professionals to provide guidance, information, help and support to donors and recipients.

ents, helping them to realise that their emotions and concerns are normal and thus feeling less alienated in the unusual and difficult circumstances in which they find themselves (Sque and Payne, 1994).

There are limitations to this qualitative study. As the study was conducted in one regional renal transplant centre, it cannot be assumed that the study participants' views and experiences are representative of all live renal transplant patients. Also, most families in this study were spousal ($n = 8$) and all participants' experiences (where transplantation was successful) were generally very positive. Caution should be exercised in transferring these findings to the experiences of all families undergoing live transplantation, particularly in relation to non-spousal donation and/or where donor–recipient relationships are problematic.

This work has raised further questions for future research in this area. As live transplantation rates are likely to increase in the developed world over the coming years, the study of physical and psychosocial outcomes for donors and recipients becomes essential (Olbrisch et al., 2002). Research needs to be prospective and longitudinal, and include investigations of live-paired transplantation (a new phenomenon in the UK of unrelated live transplantation, whereby physiologically incompatible couples/families are able to 'swap' kidneys with other couples, based on mutual physiological compatibility), donor–recipient relationships other than spousal, and the longer term (beyond 1 year) psychosocial implications of live related transplantation.

6. Conclusion

This study has provided a comprehensive insight into the live transplantation process, particularly the motivations, feelings and concerns associated with donating and receiving a kidney and the impact of transplantation on donors, recipients and, where appropriate, their families. Data show that the experiences of participants in this study relate closely to the fundamental dynamics of gift exchange, although occasionally in slightly different ways, due to the nature of 'the gift'.

It is proposed therefore that gifting provides an expedient framework for understanding factors that motivate giving, receiving and reciprocating in live transplantation. The resultant improved understanding of this process can be used to inform and develop clinical practice and future research in this area, as well as further developing the theory of gift exchange, particularly in the context of live transplantation.

Conflicts of interest statement

There are no conflicts of interest to declare with this study by either authors.

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