Encouraging Altruism: Public Attitudes and the Marketing of Organ Donation

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MEDICAL ADVANCES OF SEVERAL SORTS HAVE, OVER the last ten years, made the transplantation of human organs a possibility. In particular, the development of the artificial kidney and immunosuppressive drugs has lifted kidney transplantation from an experimental to a clinically sound procedure. The medical demand for kidney transplants is very great and the End-Stage Renal Disease (ESRD) program has eliminated financial barriers. Nothing, however, can eliminate the fact that kidneys for transplantation must come from human beings. This means these organs must be donated either by the families of accident victims or by others who die suddenly and in good health. Motivating and facilitating such donations is a matter of importance to the thousands in need of a replacement organ and, because of government financings of treatment, to those interested in public policy. This article treats the public's attitudes toward organ donation and considers what can and is being done to foster the willingness to donate. It is, therefore, about altruism and its exploitation for the common good.

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Marketing Framework

In that sense, the goal of this article is to consider the "market" for organ donation and to analyze strategies for effectively "selling" to that market. Although it is the particular problems of marketing organ donation that concern us, it is worth noting that they are but extreme instances of some of the general problems of marketing public services. Rothschild (1979) suggests a number of variables that generally influence the effectiveness of public marketing efforts. For our purposes, the most important of the issues raised is the applicability of the concepts of "product" and "price" to public marketing.

Success of any sales effort must depend, in large measure, on the existence of some latent demand for the "product" being sold. We are not referring, of course, to the medical demand for transplantable kidneys but to the donation process itself as a "product." Organ procurement agencies attempt to encourage willingness to donate organs; the act of donation is the "product" they sell. We can estimate that latent demand by examining survey results in order to see how widespread and how intense is support for and willingness to participate in organ donation. But latent demand is only part of the story because the relationship between the "buyer" and the "product" in the case of a public service such as organ donation is complex. In organ donation, since the "buyer" or contributor can receive no personal benefit from the organ itself, his motivation is, therefore, not self-evident. This article will consider what is known about *why* people support and participate in organ donation. In other words, it will consider the perceived "product characteristics" of organ donation.

Closely related to the idea of motivation is the idea of price. In the private sphere, price is a relatively simple concept, quantifiable in terms of money; but applying the idea of price to public services is often more difficult. What is the price of not littering, of driving at 55 m.p.h., or of voting? Time is often considered one element of such price, as is psychological stress (Prottas 1981). There are a variety of psychological costs associated with organ donation ranging from the anxiety of attending to fear-inducing messages to the guilt of affirming the death of a loved one by authorizing their dismemberment. But these costs are not constants and interpersonal comparisons of them are difficult. Nevertheless, a successful marketing strategy must

consider not only the nature and benefits of the product being sold but its prices, however charged.

A successful marketing strategy must also consider the distribution of attitudes toward a product within a population. Rarely are such distributions uniform and, so, market segmentation is a basic tool of effective marketing. In some public service areas—speeding, littering, etc.—marketing segmentation is inherently difficult or even undesirable. We will consider whether segmentation of the organ donation market is possible and desirable, and whether present marketing strategies deal with this issue appropriately.

In summation, this article has two closely connected aspects. It will provide a market analysis for organ donation and present what is known about the distribution of public attitudes and motivations. It will also evaluate the implications of these findings for marketing programs. In broad outline, this is an undertaking that could be done for almost any product but, in concrete terms, the unique nature of organ donation as a product has important implications. Organ donation can occur only after a sudden death and cannot, in practice, be authorized for oneself but only for a close relative. This intimate connection between organ donation and death and family plays a determinate role (or ought to) in defining marketing strategies. It also poses a most interesting and challenging problem in the nurturing and harnessing of altruism.

The Need for Human Organs

The End-Stage Renal Disease (ESRD) program was passed by Congress in 1972 (P.L.92-603). Under its provisions, all citizens covered by Social Security who suffer permanent kidney failure become eligible for complete coverage by Medicare, regardless of age. More than 60,000 Americans are alive today because of this program (Jones 1982). Perhaps 90 percent of them are being kept alive by tri-weekly treatments on an artificial kidney machine that dialyzes (removes impurities from) their blood. A far smaller number receive a kidney transplant. Last year there were approximately 58,000 people on dialysis (Demkovich 1980) and slightly over 4,000 transplants were done (Prottas 1982).

Nevertheless, renal dialysis is not the preferred method of treatment for kidney failure. The advantages of a successful transplant to a patient are substantial. Medically, a transplant patient is healthier than one on dialysis because the kidney machine cannot perform the endocrine function of an organic kidney and because it cleanses the blood only intermittently rather than continuously. Socially, a transplant is superior as most patients find the dependency on a machine very difficult and find the extraordinary dietary restrictions onerous. Finally, few dialysis patients can maintain themselves economically. Only 25 percent of those on dialysis can work outside the home (Evans, Bragg, and Bryan 1981). This, of course, increases the already difficult psychological situation.

The government also has a financial interest in encouraging transplantation. Dialysis is an expensive treatment, costing $25,000 to $30,000 per year in direct costs. In addition, most dialysis patients require income support of some sort. On the other hand, a kidney transplant costs about the same as one year's dialysis and has minimal costs thereafter. (However, only about 50 to 60 percent of cadaver transplants are successful, so the relative financial advantage of transplantation is reduced proportionately.) In a program that spends 1.8 billion dollars to treat 58,000 patients, cost-saving steps are important (Caplan 1981).

Transplantation is not, of course, a panacea for either patients or the government. Medical considerations exclude all but a minority from candidacy. Nevertheless, there is a chronic excess of demand for kidneys over their supply. Although the number of kidney transplants has shown a slow increase over recent years, the number of patients on dialysis awaiting a transplant has not declined. While estimates vary, there appear to be over 7,000 patients waiting in transplant queues across the country (Center for Disease Control 1979). Moreover, there is strong evidence that a very large reserve demand exists, i.e., patients for whom a transplant is the treatment of choice but who do not appear on recipient lists. Recent research done by the University of Toronto indicates that dialysis providers consider a transplant the preferred treatment for 85 percent of patients under 37 years of age. (As the methodology of this study was simulated case histories, it should be noted that this refers to 85 percent of patients without medical contra-indications. The percentage of actual patients would

be lower.) There is a clear imbalance between "consumer" demand for transplants and the number of transplants actually done. Most attribute this imbalance to a chronic shortage of kidneys available for transplantation (Jones 1982).

This chronic shortage does not reflect an absence of organized efforts to obtain transplantable organs. Over 70 percent of the organs transplanted in the United States are obtained from cadavers; the remainder are obtained from living relatives. While the medical advantages of a living-related transplant are substantial, the limited availability of such organs relegates them to a permanent secondary role in any serious transplantation program. (Not every person in need of a transplant has a close relative who is a suitable donor; indeed, only a small minority do. Blood relationship does not automatically mean close histocompatability matching, nor is everyone an acceptable medical risk as a donor. Finally, the willingness to donate cannot be assumed.) Therefore, the organ procurement system of the United States is dedicated to obtaining cadaveric kidneys. This system is large and totally funded under the ESRD program. It now consists of approximately 140 procurement agencies. These agencies procured, in 1980, 4,344 cadaveric kidneys, by the best estimates available. Over 100 of these agencies are based in transplantation hospitals and operate as a division of those hospitals. Twenty-five agencies are nonprofit corporations without formal affiliation with a hospital.

These Independent Organ Procurement Agencies (IOPAs) are the more progressive and effective sector of the kidney procurement industry. Although there are only about two dozen of them, as opposed to over a hundred hospital-based agencies, they procure approximately 40 percent of the nation's cadaveric kidneys. Much of the data for this article comes from an extensive investigation into their behavior.

The basic problems of procuring kidneys for transplantation are twofold. First, the procurement agency must obtain information about and access to potential donors. All potential donors die in hospitals and most die within several days of being admitted. The identification of these donors must, therefore, come from the medical staff in the hospitals who treat them before death—usually neurosurgeons and nurses in intensive care wards. In many ways this is the most difficult and critical problem facing organ procurement. But even if it is successfully overcome it is not sufficient. The necessary final stage of the process is to obtain permission from a responsible relative of the

deceased for removal and transplantation of the organs. The goal of marketing organ donation, referred to by those in the field of public education about organ donation, is to increase the likelihood of such cooperation.

Public Attitudes

At first glance, one might not expect it to be very difficult to get families to permit organ donation. There are many indications that the American people are prepared to behave with commendable altruism in the matter of organ donation. Public opinion surveys over the last 15 years have consistently found that Americans have a very positive attitude toward organ donation. In 1968, a Gallup poll found that 70 percent of Americans expressed a general willingness to become organ donors (Kaufman et al. 1979). A smaller poll done the following year in St. Louis found much the same thing (Kidney Foundation of Eastern Missouri in Metro-East 1975). Others have since found even higher levels of public support. Surveys done in Texas (Cleveland 1975a) and Los Angeles in 1975 (Transplantation Council of Southern California 1975) found favorable attitudes among 77 percent or 78 percent of those surveyed. The St. Louis survey of 1981 found positive attitudes in over 80 percent (St. Louis Regional Transplant Association 1981)! (See Appendix I for a description of this and other unpublished surveys referred to in this article.)

But the willingness to express a positive attitude toward a socially approved activity is not the same as a willingness to take concrete action. It is not surprising to find a deterioration of supportive responses as the questions asked become more concrete and personal. This is seen in the 1975 Los Angeles survey where support for transplantation dropped 21 percent when a specific organ was mentioned. Support dropped an additional 20 percentage points, to 36 percent, when people were asked if they would actually give permission to remove the kidneys of a dead relative! A survey done in the same year in St. Louis had almost identical results, 57 percent and 38 percent respectively. (In all cases, the question presumed the relative had not expressed an opinion on donation while alive.) In each case a consistent deterioration of support is seen as one moves from abstract support to specific intention.

For organ procurement, these figures seem to be a modest cause for optimism. There is a large reservoir of positive attitudes toward organ donation—indeed, an increasingly large one if the Texas survey is a valid measure, as it found an increase of positive responses from 69 percent to 78 percent between 1969 and 1974. If the more concrete expressions of support are of a lower magnitude, they are certainly not trivial; they indicate that more than one-third of Americans have a very strong willingness to cooperate in donation. The basic problem for organ procurement agencies, therefore, must be 1) to obtain access to those willing to donate—and this is a matter of getting cooperation from hospitals—and 2) in the field of public education or public marketing to mobilize the widespread but weakly felt attitudes of approval and support.

Marketing Goals

It is not a simple task to market organ donation. As in any marketing endeavor, the first question must be: Exactly what are you trying to get people to do? In the last analysis, of course, the answer is that you wish permission to remove the kidneys of a cadaver, but the immediate issue is what you seek *now* from the living audience. Ideally, you want someone to bind themselves, while living, to donate their organs in the event of their death. Every American state allows this sort of commitment based on the Uniform Anatomical Gift Act, developed by the National Conference of Commissioners on Uniform State Laws, adopted at Chicago, July 1968. This act permits a person to make a "will" making a bequest of his or her body. The most obvious goal of public education in organ donation is, therefore, to get people to sign "donor cards," a step made easier in many states by programs placing such cards on drivers' licenses.

Unfortunately, this relatively clear-cut goal is largely irrelevant to the actual end of obtaining donated organs. Two factors account for this. First, in every locale researched, police and hospital procedures quickly separate the accident victim from his or her wallet or purse. As a result, in only a negligible percentage of cases are procurement agencies aware of whether a given patient has signed a donor card. Of even greater importance, however, is the policy of hospitals and procurement agencies not to excise an organ without the express

permission of the decedent's family—regardless of the existence of a signed donor card. This policy reflects, in large part, the perceived vulnerability of organ procurement efforts. No agency or hospital wants any individual's organ so badly as to be willing to face the conflicts, adverse publicity, or legal action that might follow from acting against a family's wishes. In addition, the individuals involved in the process, nurses and organ procurement officers especially, are very concerned about the feelings of the decedent's relatives and, generally, would fail to procure the organ rather than increase their pain. Finally, the organ procurement agency knows that it depends on the cooperation of the hospital staff and so realizes that actions that make the organ procurement process more painful for them are counterproductive.

The ineffectiveness of a personally binding commitment makes the task of marketing organ donation more complex. Who must be convinced to do what under these circumstances? The final stage in the actual process of organ procurement gives the answer; in the end, a relative gives or withholds permission for the donation of someone else's organs. This is a far more complex situation and alters the next question that any marketing strategy must address.

Donation and Motivation

Once you know what you are trying to get people to do, you must decide how you're going to persuade them to do it. In this case, one must think about why a family would agree to donate a member's organs. The way this question is answered ought to influence the entire nature of marketing organ donation. Families may be acting from any of several possible motivations when they permit organ donation: they may be acting out of altruism; they may be carrying out the decedent's wishes; they may be acting to mitigate the impact of the death; or, they may be taking an opportunity to "rehabilitate" the deceased via a socially approved act. These are not mutually exclusive explanations and, indeed, some mix of them probably operates within a single decision.

We have already seen that there exists a very large pool of expressed altruism among Americans in this area. Moreover, when those who have committed themselves to actually donate in the event of their

own deaths are questioned about their motivations, their answers are generally framed in altruistic terms. In both the Texas (Cleveland 1975a, 1975b) and British (Moores et al. 1976) surveys, between 64 percent and 70 percent of those who stated a determination to donate gave as the reason a desire to help others. Of course, this does not quite get at the question being asked as these individuals are responding about their own motivations regarding their own bodies. Data on the actual motivation of donating families is much more limited, but does exist.

In 1982, a large organ procurement agency surveyed, by mail, 98 donor families in New England about their feelings about the donation they had, in fact, authorized (New England Organ Bank 1982). They received an 80 percent response rate. The results of this survey substantiate the important role of altruism. When asked to explain why they had agreed to permit donation, 79 percent gave as one of the reasons a desire to help others; this is 20 percentage points more than that given for any other single reason.

Another constellation of reasons given for permitting donation has to do with the desire to somehow mitigate the death of the family member. The Texas survey, already referred to, found that 49 percent of those committed to donation gave an answer along those lines as a reason for their decision. The New England survey confirms that this is true for families as well. Fifty-nine percent of families gave as a reason their desire that something positive come out of the death of their relative. Additionally, large percentages answered that they were motivated by the thought that the donation would be a memorial to the deceased and/or that somehow the deceased would "live on" through the donated organ. The percentages were 29 percent and 40 percent respectively. These two answers were very highly correlated indicating that this image of mitigating death through organ donation is a significant factor for many families. This conclusion is further reinforced by the impressionistic evidence of organ procurement officers. More than 50 such people in every part of the nation were interviewed as part of a project investigating effectiveness in organ procurement. They report that families frequently explain their decision to permit donation in terms of seeking a type of continued life for their relatives.

There is also reason to believe that families agree to donation more readily if the deceased has expressed an intention to donate, or at

least has supported the concept of organ donation. The 1975 surveys in Los Angeles and St. Louis and the 1981 survey in St. Louis each contained a question asking if the respondent believed that their family would carry out their wish to have their organ donated after their death. In each case, the yes response was between 60 percent and 68 percent—almost twice the positive response to the question asking if they would authorize donation for a relative who had not discussed the matter with them. If people expect their wish to donate to be honored, it is certainly reasonable to assume that they would honor that wish in others.

The New England survey supports the contention that the decedent's wishes are an important factor in the family's decision. While only 25 percent of the respondents reported the expressed preference of the deceased as a reason for their decision, this figure is not comparable to those discussed earlier. The 25 percent represents the intercession of two events: the decedent's expression of preference, and the family's willingness to act upon it. The impact of the decedent's expressed wishes is more unambiguously seen in the strong relationship between those families who initiated the donation process themselves and those that gave the decedent's preference as the reason for agreement. This relationship is statistically significant at the .01 level. What makes this extraordinary is the rarity of family-initiated donations. Nationwide, they are a negligible percentage of all donations and are felt to represent people with the highest commitment to organ donation. This survey indicates what we might logically expect; that something personal and immediate best motivates a family to think spontaneously of organ donation.

A fourth kind of answer in the New England survey indicates a motivation influenced both by the wishes of the deceased and a desire to mitigate the death of a family member. Fifty-six percent of respondents stated that they agreed to donation because it was consistent with the beliefs of the deceased. This answer could be understood as their attempt to act on their understanding of the decedent's preference in the absence of explicit discussions, or it may be an attempt to "rehabilitate" the deceased by attributing to him or her admirable altruistic sentiments. Those involved in organ procurement report that the latter is a common response of families. It is certainly consistent with our cultural disinclination to "speak ill of the dead." On the other hand,

it is impossible to say how much of this response ought to be categorized as mitigation and how much as decedent's preference; undoubtedly it's a mixture, perhaps even within each individual psyche.

Marketing and Motivation

These data indicate that several threads ought to be included in any marketing effort for organ procurement. The most concrete and perhaps productive aim ought to be to motivate people to express their wishes to their families. Indeed, the major argument for donor cards rests on this and not on their status as wills. The practical impact of the Uniform Anatomical Gift Act and donor cards is to provide an occasion to inform one's family of the potential donor's wishes.

Of course, a donor card is not a necessary element in such an exchange. Very few people actually sign donor cards, but far more people discuss organ donation. Among those surveyed in New England, four times as many acted on discussion with the donor than acted because they knew of a signed donor card. Four recent surveys (the two 1975 surveys, the 1981 St. Louis, and the 1981 Nashville survey) included questions about discussions among people about donations. Their findings differ considerably. The Nashville survey found that 16 percent of those surveyed had discussed organ donation; the 1981 St. Louis survey reported 20 percent; and the two larger, earlier surveys reported approximately 30 percent. These figures are so much lower than those indicating willingness to act upon expressed wishes that this seems an obvious area to concentrate marketing efforts. Not only is there a large pool of people willing to be persuaded, but the action being asked of them is simple and concrete. Even more, there is some evidence that behavioral changes can be brought about in this area by marketing. Both the Nashville and St. Louis surveys were conducted before and after a major public marketing effort in those cities. Virtually the only change in the answers received was in the percentage of people who had discussed organ donation. The results are not clearly significant but can be seen as hopeful. The change in Nashville was from 16 percent to 22 percent, a very marginal shift statistically. In St. Louis the shift was greater, 20 percent to 31 percent, but, unlike Nashville, the question was not limited to discussion with family members. As a result, its significance is a bit harder to evaluate.

The advantage of encouraging people to take a concrete action of some sort in a marketing effort is obvious. It allows a response at the time of receiving the message; the time between receiving a message and being able to act on it is clearly a problem for organ donation. In addition, the action tends to reinforce the response to the message and, in fact, extends it. If the recipient of the message discusses it with a family member, not only does he make his views known but he also gets a response from his spouse. Presumably, those favorably inclined predominate among people who act on the urging of the advertisement, and they may act as opinion leaders on this issue in their families. This is especially true given the overwhelming perception of organ donation as morally admirable. Finally, it seems that only concrete requests for action are recalled readily by the public in this area. The Nashville survey included a question about the content of the advertising campaign. The only answer recording any change was the one referring to signing the donor card. Indeed, more than four times as many people recalled that message as recalled any other.

If the primary goal of marketing in organ donation ought to be to get people to discuss the issue with their families, this does not downgrade the importance of altruism as an appeal to motivate that discussion. Altruism is not an easy "product" to sell. The basic issues determining the effectiveness of communications in selling are product and price. From a marketing point of view, the role of the product is to reinforce the behavior urged by the advertising. Price, of course, affects the willingness of the consumer to act.

The cost of involvement in organ donation is subtle, variable across individuals, and generally higher than one might have imagined. Superficially, organ donation might appear to be an extremely inexpensive product. All major religions and the generality of public opinion consider it morally and socially laudable. It is a "prestige product." Manifestly, the utility of one's kidneys after death is negligible. To be an organ donor, therefore, is to give away something of no value and to gain status thereby. However, our cultural attitudes toward death and the great time and psychological distance between the decision to participate and the opportunity to do so alter this picture.

Death. Americans have a strong reaction to the word and the prospect. It is, indeed, almost a taboo in our society. Getting young, healthy adults (the core of the donor pool) to think about death is

hard. Getting them to make plans for after their death is harder. Getting them to discuss their death with their family yet harder. Getting them to do this based not on their financial responsibilities to their dependents but purely as a consideration of benefits to strangers multiplies the problem even further. And, finally, to force discussion not merely of death as an inevitable end, but of death of an improbable and particularly tragic type, causes the task of marketing in organ procurement to seem daunting indeed. So sensitive is the issue that, until very recently, organ donation advertisements avoided completely the use of the word death!

So, in the first instance, the primary cost of involvement in organ donation is confronting fear. One must admit and deal with one's own mortality. Perhaps as important, one must confront one's family with a discussion of one's own death and deal with the anxiety and perhaps anger that results. How great a price this is for an individual is very difficult to anticipate. Research supports the relationship we'd expect, i.e., that donors are less anxious about their mortality than nondonors (Cleveland 1975b), but that provides no guidance as to the distribution or intensity of fear, still less about its felt "cost." Indeed, most of what we know about this matter are details about our ignorance. We might expect that religious people would be less threatened by death and, so, more willing to donate. But donors are, on the whole, less religious than nondonors (Simmons, Simmons, and Simmons 1971). And, as Burnett and Wilkes (1980) report, the findings of research on the effect of "fear appeals" are so contradictory as to be of little help. Finally, the most commonly *expressed* fear encountered by those involved in organ procurement is the fear that agreeing to become a donor would negatively affect the treatment one receives in the hospital! Whether this is a real fear or an excuse is not known. The fact that it is unrealistic provides little evidence either way. Intuitively, we recognize that fear is a basic cost of involvement in organ donation, but we are unable to specify its magnitude or distribution.

The unusual emotional distance between the circumstances in which the pro-donation communication is received and the circumstances in which permission to remove the organs is made is also a problem. People are asked to decide to donate their own organs at a time when it is their wish and expectation that they will never have the opportunity. The final decision to donate is made in the midst of profound and

immediate tragedy. Altruism is far easier in the first than it is in the second environment. And, indeed, the decision asked of people is also substantively different, acting for themselves in anticipation versus for someone else in actuality. So while the "price" of discussing the matter with one's family may be fear, the cost of actually agreeing to permit the dismemberment of a newly dead relative may appear in quite a different guise. Of course, the approach at the "point of sale," after death has been declared, is by an individual employee of a procurement agency, and depends on techniques different from those of mass marketing. Nevertheless, the influence of mass-marketing messages on that encounter is made particularly difficult to evaluate by the simultaneous change in the product (from your kidneys to another's) and coinage of the price (from fear to guilt, perhaps). Certainly these shifts, by further complicating the price issue, further complicate the task of marketing organ donation.

Target Populations and Attitudes

Consideration of the goal and basic content of the message does not complete the responsibilities of those trying to "sell" organ donation. It is also necessary to decide who shall be sold and, in a closely related issue, via what medium they will be approached. This is essentially an issue of market segmentation. Such segmentation is basic to marketing strategies in private markets and is very desirable, if not always possible, in public areas. In the case of organ donation, there are enough salient differences among population groups to make segmentation worthwhile.

Age is important for a number of reasons. Certain people can be excluded as targets because they are excluded for medical reasons as potential donors. Most organ procurement agencies will not take kidneys from people over 55 years old. Therefore, this segment can be eliminated as a target group. The other end of the age line can be excluded for different reasons. Even the very young are desirable organ donors; most procurement agencies will take a kidney from anyone over the age of one. However, the young are not a reasonable target segment because they are not generally allowed to make decisions of this sort themselves nor are their opinions on such matters widely held to be informed enough to be considered. In addition, the experiences

of several procurement agencies indicate that adults often object to having children exposed to messages supporting organ donation. The exact point at which these considerations cease to operate is difficult to define. Certainly, several organ procurement agencies operate active programs aimed at juniors and seniors in high school—16 to 18 year old. If 15 is taken as the youngest age appropriate to attempt to influence, then an additional 22.7 percent of the population is excluded. Nevertheless, 15 to 55 is a very great age range and includes 56.4 percent of Americans (Bureau of the Census 1981).

Unfortunately, there is an additional significant line of differentiation—race. Black Americans are far less likely to express support for organ donation than whites. Cleveland found a 20 percent level of support among blacks while finding a 67 percent level overall (Cleveland 1975a). The actual willingness to donate shows a yet greater disparity. In the 8 cities studied directly, the average black population is 29 percent (Bureau of the Census 1981). In most of those cities the number of black donors is negligible; in none is it over 1 percent. There is no nationwide figure, but it is the universal appreciation of those in the organ procurement business that, with very few exceptions, organ procurement agencies do not obtain any significant number of black donors.

We have no systematic data with which to explain this phenomenon but, based on the reports of those employees of organ procurement agencies that deal face-to-face with donor families, several explanations can be tentatively suggested. The first is that the difference between white and black rates of organ donation may be exaggerated. It is possible, indeed probable, that at least part of the difference between whites and blacks is really a class-based rather than a race-based difference. Certainly class, especially as measured by education, is correlated to attitudes toward transplantation and organ donation among whites (Cleveland 1975b; Transplantation Council of Southern California 1975; Simmons, Simmons, and Simmons 1971). And most organ procurement specialists report that middle-class families are far more likely to agree to a donation than are lower-class families. Given American race/class correlations, this may explain at least some of the apparent difference. Unfortunately, unlike race, class is not a simply observable fact. No agency contacted had any statistics on the class make-up of their donors, although all kept records by race (usually

in the form of white, black, Hispanic, and Asian). It is, therefore, not possible to compare racial differences while keeping class constant among actual donor families.

Based on the education/attitude relationship found by survey and the race/education correlation in our society, it is plausible to attribute part of the racial difference in donation rates to class. The remainder, whatever its exact size, probably reflects the generally poor relations between the races in the United States. There is only limited and anecdotal evidence to support this thesis, but it is all too plausible. There is a small number of black organ-procurement specialists working for the agencies visited. They report that black families will express their belief that organ donation only helps whites and that they are not inclined to cooperate to that end. How widespread this attitude is is impossible to say, but we can't be too surprised that, in a racially polarized society, altruism is bounded by the limits of racially defined communities. Even in the absence of specific racial hostility, black donor families may easily have a greater sense of alienation from and fear of the institutions asking them to donate their relative's organs. The hospital staff will almost without exception be white. Under such circumstances, the anger and mistrust so often exhibited by bereaved families might well be directed toward the hospital and the procurement agency.

It is bitter irony that the view that blacks are being asked to provide replacement organs for whites is so completely wrong. Blacks represent about 27 percent (Prottas 1982) of those being treated under the ESRD program and, at least in the cities visited, comparable percentages of those awaiting a transplant. Moreover, as the distribution of antigens differs somewhat between the races, the dearth of black donors probably has its most adverse effects on blacks awaiting a new kidney. This aspect of the problem clearly reflects a failure of public education and marketing.

There is another racial factor that appears to explain part of the disparity between black and white donations. Organ procurement workers report that, on average, they obtain permission from between 60 percent and 80 percent of all white families they approach. They obtain permission from only 0 percent to 20 percent of the blacks approached. This difference explains much of the difference between black and white donation rates, but not all of that difference. Upon

investigation, it appears that these procurement specialists also see a disproportionately small number of black families! In order to approach a family about donation, the procurement worker depends on getting a referral from the hospital staff informing him that a potential donor exists and can be talked with. It appears (but this is far from demonstrable) that hospital staffs are less likely to refer blacks than whites. Racial prejudice need not be the explanation; it is sufficient that the alienation that disinclines blacks from agreeing to donation also be reciprocally felt by the hospital staff. The staff doesn't refer all potential donors in any case, only those they consider likely to agree to donate. Their reading of this probability, combined with the statistically lower reality, simply may lead them to "overselect out" black families. This kind of work-a-day stereotyping is quite common among street-level bureaucrats (Lipsky 1976). This is not a public education problem and may be amenable to change in a variety of ways via efforts to encourage staff cooperation in organ procurement programs.

The last factor is, in many ways, the most speculative. Procurement specialists believe that the most common reason they are refused has to do with intrafamily relationships. Tightly knit nuclear families, they say, find it easier to agree to permit the donation than do broken families, single parent families, or even extended families. In the archetypical case of the death of a teenage child, a family in which the parents are not on good terms or are not both available tends to refuse permission in order to avoid conflict among relatives. In the same way, extended families have more complex lines of authority and relationships and so decision-making is more difficult. But the actual cause of lower permission rates from such families is unclear. Hispanic workers sometimes say that the problem with extended families is lack of familiarity on the part of Anglo workers rather than anything intrinsic to Hispanic family make-up. And this "cultural" argument can be expanded to account for part of the lower rate of agreement of blacks. In any case, "nontraditional" families represent a problem to those interested in organ procurement. How much of the problem is intrinsic to the family structure (and so ought to be dealt with, if possible, through public education) and how much is due to the lack of familiarity with those family types on the part of the organ procurement workers is not known.

Target Populations and Marketing

The bottom line, of course, is that there exists a vast difference of donation rates between whites and blacks, whatever its underlying source. One question that this raises is whether one or the other of these groups ought to be the particular target of public marketing for organ donation. There are arguments on both sides.

The black population, and perhaps the working class in general, is clearly a largely untapped resource. The most productive use of marketing resources may be to "break into" this market segment. At least part of the low level of donation is attributable to lack of good information. It is altogether possible that increasing black donation rates from less than 1 percent of the total to 3 percent or 4 percent would not be hard. The first increment could come from those blacks already the easiest to mobilize toward altruism. It is possible that basic divisions of our society will make it extremely difficult to bring black rates up to white, but substantial reduction of the difference may not be hard.

By the same token, it can be argued that the law of diminishing returns already operates among white middle-class donors. Their attitudes are already so pro-donation that no significant increase is likely and, if the organ procurement specialists are to be believed, they already are agreeing to permit donation 60 to 80 percent of the time. (But recall that these figures ought to be treated with caution. Aside from the obvious danger of overreporting success, there remains the issue of preselection. Getting the hospitals to inform an organ procurement agency of potential donors is one of the critical and most difficult parts of organ procurement, and not all potential donors are referred. The possible social biases in referrals have already been mentioned. It is also probable that the hospital staff's judgment of the probability of success plays a role in all decisions to refer a case to a procurement agency. Therefore, only those most likely to agree are ever seen by the agency representative. Nurses admit to this screening although it is officially discouraged by most procurement agencies.) Any increases among this population would have to convince those most resistant to persuasion.

On the other hand, there are arguments for concentrating on what seems to be the easiest market segment. There appears to be no serious

opposition to organ donation among middle-class whites; failure to cooperate appears more the result of apathy than hostility. Motivating this segment does not require dealing with, or circumventing, any basic societal conflicts. In addition, while the percentage of donors from the white middle class is relatively high, the absolute number who don't agree to donation or who are not approached for one reason or another is great. It is possible that here the greatest return in number of organs can be obtained for the least investment.

In the absence of systematic research, it is impossible to be sure which of these strategies, or what mix of them, is best. Any decision will, in turn, raise other questions about the most efficacious content of marketing messages. If blacks are to be the target segment, then the cause of low-donation rates among them must be determined. It is now impossible either to answer the question of what is the best strategy or to sensibly consider the appropriateness of various message contents.

Present Approaches

Despite our lack of knowledge, actual public education and marketing efforts have made a de facto decision on these matters. These decisions, in favor of the white segment, are not the result of an analysis of desirable targets, but an artifact of the medias being used to communicate with the public.

The organ procurement agencies of the nation are those institutions most actively involved in promoting organ donation and, of them, the 25 independent agencies are the most active. They spend perhaps $250,000 a year on marketing organ donation. There is, however, a great deal of variation in both the amount of money spent and the kinds of marketing undertaken. Some independent organ-procurement agencies budget nothing for public education (as all call their advertising in favor of organ donation); others spend 7 percent of their entire budget on it.

The total spent yearly on marketing organ donation in the United States can only be guessed at. Information on the way the hospital-based procurement agencies spend their money is very hard to come by. In addition, local kidney foundations also include some advertising in support of organ donation among their other public education

efforts. If the expenditures of the independent agencies are assumed proportionate to their share of the number of organs obtained, then the entire organ-procurement system spends about $600,000 a year. This probably overestimates the actual amount for reasons beyond our concern here. Some addition ought to be made for the local kidney foundations, but its size is unknowable. All things taken together, a guess of $600,000 to $700,000 a year for public education on organ donation is probably not unreasonable—but it is only an educated guess.

The particular activities that appear under the heading of public education among procurement agencies are extremely varied. Everything from newsletters to video-taped interviews to night classes to distributing T-shirts is being used. However, the preponderance of time and money goes into two kinds of approaches: radio spots and lecture circuits. Both tend to concentrate the messages among the white middle class.

Radio is the most common form of public education. Its widespread use reflects the availability of free public-service spots. FCC regulations require all broadcasters to air a certain number of these spots and organ procurement gets its share. In addition, the South Eastern Organ Procurement Foundation provides prepackaged spots free or at minimal charge. This form of public education can, therefore, be done with virtually no effort or expense. Still some agencies do go to considerable expense. Several actually prepare radio and TV spots locally. These, and others who do not go quite that far, also invest considerable time developing good relations with local media.

Appearances on local talk shows is also a feature of many advertising campaigns. Those agencies with an inactive public education program accept invitations; those who are active seek them.

Many agencies strongly committed to public education depend heavily on lectures to groups. Strategies differ in this and one of two targets is generally emphasized, civic groups (like the Elks) or high schools.

The procedures differ somewhat depending on the target, but follow the same general patterns. A short prepared talk is given emphasizing kidney disease and its treatment. The need for kidneys is emphasized and the organ procurement process is described. If given to a civic group, the talk is usually at a regular meeting. If given at a high school, it is usually to juniors or seniors in a health-related class.

Most agencies will send a speaker anywhere if asked, but those pursuing this sort of public education strategy actively seek opportunities.

They systematically contact their target groups via mail and telephone and, over the years, develop a regular "clientele." Because such a lecture "circuit" is very time-consuming, those agencies doing this usually have a full-time employee for it. Such an employee may speak at 80 schools and give 250 talks a year! Both of these approaches, in fact, concentrate on the white middle class. Civic groups visited are always traditional bastions of the white middle class, and a breakdown of the schools visited in the most active agency showed less than 9 percent of them to have any significant percentage of lower class black students. This is not a conscious decision by the public education officer, but simply reflects which schools have expressed an interest in the program.

Media-based public education programs have taken the same road. Most broadcast media aim at those with buying power and, therefore, any shotgun approach to media results in more messages going to the middle class than to other segments. Dependence on free, public service spots, of course, makes selectivity difficult. Only a special effort to employ and develop contacts with radio stations or newspapers serving black populations could reverse this bias. In general, therefore, the target of marketing efforts has been determined by the mediums used rather than the mediums being selected based on appropriateness for program goals.

Conclusion

Few people die for lack of a kidney transplant, but thousands live a dependent, restricted, and sickly life. Medical progress in immunology is likely to increase the number for whom a transplant is a desirable option. Nor are the potentialities of transplantation limited to kidneys. Other organ transplants are still largely experimental now, but heart and livers are both close to transcending that stage (if they haven't already done so) and other organs may follow. However society chooses to deal with these new capabilities, it has committed itself on the matter of kidney transplantation; the law, the capacity, and the demand exist.

Altruism also exists. Everything we know about people's attitudes toward organ donation indicates a widespread appreciation of its morality and desirability. Everything we know about the actual number of

kidney donors indicates that much of this reservoir of altruism is untapped.

Technical advances and the societal changes they engender have not been noticeable for increasing the sense of community among people. Some have, therefore, argued that opportunities for permitting such acts of unselfishness are valuable in and of themselves and ought to be fostered (Titmuss 1972). In the case of organ donation, this "gift relationship" is far more complex than it might be in the case of, say, blood donation. The two acts are similar in that they involve a free gift of a product only producible by human beings, one that cannot be substituted for by any amount of any other resources—not even that sovereign cure and most basic unit, money. But donation of kidneys and similar organs also involves the giver in other basic human realities (if we may hope that altruism is such): death and family relationships. For this reason, the exercise of altruism in this area clearly makes more demands on the givers than any other situation.

The role of public marketing in organ donation must, therefore, be to facilitate the exercise of widespread altruism rather than to engender that altruism. This both limits the role of marketing and increases its challenge. Altruism already exists and does not have to be engendered. But the psychological obstacles (we do not here speak of the practical ones) to the exercise of that altruism are substantial. It is the role of marketing to help overcome them. The problem, in other words, is to help people act on their good intentions. The most direct steps that can be taken to this end are not in the area of mass marketing, but in improvements in the quality of the personal salesmanship done at the point of sale. (There is also room for great improvement in obtaining access to potential donors. This involves another kind of marketing, which we do not discuss here, aimed at motivating medical professionals to refer potential donors.) The goal of public marketing must be to increase the receptivity of families to the face-to-face sales pitch.

At least among the white middle class, it appears redundant to do this by proposing the social and moral desirability of organ donation. As surveys show, this point has already been conceded. Indeed, the survey results, combined with the reported rates of actual agreement, may imply that no marketing efforts of any sort need be aimed at this market segment. However, more complete and objective data on agreement rates is needed before such a sweeping conclusion is justified.

If any message ought to be communicated to this group, it is certainly the necessity of intrafamilial communication of attitudes toward donation. In the case of the white middle class, this step is probably sufficient to substantially fulfill the role of public marketing, as it will probably have a direct effect on the success at the point of sale—after death has been declared. While it may not be sufficient for all other market segments, it remains a necessary element of successful strategy.

The most commonly used "public education" format, the radio spot, seems unsuited to encouraging family discussion of an anxiety-producing subject. Such spots are short and appear sporadically. It is improbable that they can engender the degree of involvement in the product necessary to motivate a family discussion. On the other hand, the lecture circuit approach probably is a sufficiently "large event" for the audience that some family discussion may follow. Its major shortcoming is cost, the time and effort per listener is very high.

News stories, especially feature stories, are probably the ideal method of influencing people to discuss organ donation within their family. Distributed by the mass media, they are heard by many; because their content goes beyond the exhortatory, they provide a basis for discussion. Indeed, the information in the story may provide a nonthreatening introduction to a threatening issue. Placing such stories might, therefore, be considered the most desirable kind of public education, although the difficulty of doing so regularly is obvious.

Another approach that may be effective is concentrating pro-donation messages within a short time span. Some procurement agencies are trying this method. During a selected week or month, they attempt a veritable "media blitz." The efficacy of this approach lies in the possibility that the campaign itself may become a topic of conversation, providing opportunities within the family of expressing a willingness to have one's kidneys donated. The probability of such conversations could be increased if the content of the campaign emphasized the importance of discussing the issue instead of simply the desirability of donating. The theory underlying this concentrated approach is that a certain threshold of involvement on the part of the listener is necessary to motivate a family discussion of organ donation. This threshold is more likely to be obtained if all the marketing messages arrive at the same time than if they are distributed uniformly over time. It further assumes that expressed support for organ donation need not be reinforced regularly to influence the decision of the family

in the hospital. Both assumptions seem reasonable, but neither has been validated by research.

Finally, there are other variables whose impact can be expected to be important but about which we have no information. The context of an organ-donation message may affect the probability that a discussion will follow. Messages received when the family is together may be more efficacious than those received individually. Those received from certain opinion leaders may have more effect than those received from others. I expect, for instance, that physicians would be poor spokesmen while clergymen would be good ones. It is also natural to assume that the tone and content of the message is important. Some agencies employ cute cartoon figures in their ads, others refer to the suffering of children! Unfortunately, in all these matters, we simply do not have the data to allow us to make sensible decisions.

There remains the issue of the differential approaches to different market segments. Ideally, we need data on why different groups do not donate in order to choose strategies for overcoming their reluctance. Lacking that data, we must resort to inferences based on the nondonating group's characteristics and the anecdotal evidence provided by procurement coordinators. Race appears to be a major factor affecting willingness to donate, although we cannot confidently separate out the independent effects of class and race per se. Surveys indicate that education is closely associated with pro-donation attitudes; experience shows that actual donation rates by blacks are extraordinarily low.

There are any number of possible explanations for the relationship between class, race, and donation rates. Research is needed to delineate and quantify the correct constellation of factors. Lack of information and lack of trust in the involved institutions probably will turn out to be elements in whatever relationship is finally discovered. The two are closely connected. People lack information, which makes them suspicious of the process; suspicion of those involved make people disbelieve the information favorable toward donation that they do receive. If this sequence plays a major role in explaining low donation rates, then marketing efforts may be a help.

The most commonly expressed fear about organ donation is that organ donors will not be adequately cared for in a hospital because someone will want them to die to get their kidneys. The area of greatest confusion, as reported by procurement coordinators, is the meaning of brain death. The fear and lack of knowledge are clearly

complementary. These factors, at least, can be affected by public education.

A marketing strategy aimed at eliminating this fear and ignorance could use broadcast media. Here the goal is to transmit information, not alter behavior directly, so less involvement on the part of the audience is needed. The media would have to be carefully selected to be sure the message was actually going to the proper segment. Most cities have radio stations serving a black audience; many large cities have black community weekly newspapers. In some areas of the country, other minority groups, such as Hispanics, are similarly served. To increase the information's credibility, opinion leaders in that community could be recruited to deliver the message. In the case of black communities, a reminder of the number of blacks awaiting transplantation might also be helpful. This is a low-risk, low-investment strategy. Its effectiveness will depend on whether low donation rates are primarily caused by lack of information and specific fears. If its sources have more profound bases, there may be no "latent demand" for the product; in which case, marketing can do little. In any case, it is hard to see how such a campaign could do harm or, for that matter, how it could be less helpful than the present complete neglect of this market segment. Certainly, until more complete and sophisticated data is available, it is worth trying, if only as a practical social experiment. Policy often has to be made before scientific certainty is possible.

In the end, all one ought to expect from public marketing in organ procurement is to increase the salience of the altruistic impulse. The death of a family member generally brings with it grief, love, guilt, and fear. This is not the best environment for the introduction of unselfish generosity to strangers. But if public marketing can increase people's emotional commitment to organ donation before tragedy strikes, a family can carry into the hospital altruism as well as dread. This would decrease the psychological distance that needs to be traveled to decide to authorize organ donation. Certainly nothing can decrease that distance so effectively as an explicit commitment to the deceased based on earlier discussions. But, equally, the underlying motivation of all who contribute to the decision to donate must be willingness to help strangers without the least prospect of personal advantage.

The social and psychological forces involved in organ donation are immensely powerful. An encounter with a family confronted with the

sudden death of a child or spouse is profoundly shaking. The impact of any public messages, in such circumstances, must be slight in comparison with private feelings and relationships. But altruism is also a powerful impulse and, perhaps, requires only slight assistance to prevail.

Appendix: Survey Data Sources

There are five surveys referenced in this article that are unpublished and unavailable to most readers without considerable effort. Some detail as to their scale and methodology may therefore be helpful. The five naturally break down into three groups: general surveys done prior to and independent of marketing efforts; "before and after" surveys done to evaluate marketing campaigns; and a single survey of actual donor families.

The surveys by the Transplantation Council of Southern California and that done for the Kidney Foundation of Eastern Missouri fall into the first category. They are the earliest and largest of the group. The California study was designed to obtain a representative sample of major demographic and socioeconomic groups in Los Angeles County. The sample size was 506 and all respondents were between 15 and 50 years of age. All interviews were conducted in the respondents' homes. The study is flawed by a rather arbitrary division of respondents into four categories according to their "likeliness of donating." I have not employed these categories in reporting the data, but have limited myself to employing the uncategorized response figures for individual questions. The survey instrument consisted of 29 questions and was, essentially, closed-ended. Twelve of the questions had to do with respondent characteristics and 9 probed the sources of respondent information about transplantation. The bulk of the remainder dealt with attitudes and knowledge about donation and transplantation and were internally consistent.

The Kidney Foundation of Eastern Missouri survey was done in St. Louis four months after the Los Angeles study was completed. It consisted of three separate data collection efforts: a general public survey ($N = 315$), a donor card-holder survey ($N = 83$), and a physician survey ($N = 81$). The first two were purposefully copied from the Los Angeles survey. The methodology was the same and, with very few

exceptions, the questionnaires were identical. It is, in fact, largely a replication of the earlier research.

The second two surveys, those done for Dialysis Clinics, Inc. and the St. Louis Regional Transplant Association, were designed to test the effect of specific marketing campaigns. Both employed personal interviewing at the respondent's home, had approximately 300 respondents, and consisted of two paired surveys, one before and one after the campaign. Both were done for the local procurement agency and clearly had a vested interest in findings supporting the effectiveness of their "public education" efforts. Both were short questionnaires of about one dozen questions, of which perhaps half had substantive general content. In each case, the remainder were either of purely local applicability or provided demographic information. In the case of the St. Louis survey, the paired samples were ill-chosen in that the educational level of the "post" group was substantially higher than that of the "pre" group.

The last survey, by the New England Organ Bank, is unique. It is a mailed survey of donor families. The respondents were all families that had agreed to a donation in 1981. The list was very complete and may, in fact, represent 100 percent of donor families. The response rate was 80 percent. The questionnaire itself was extremely short, 6 questions, contained an unfortunate mix of closed and open-ended questions and no demographic or social data. I analyzed the raw data for the agency. A second round of surveys is now being undertaken, including for the first time anywhere, a survey of families who refused to donate.

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