



### **Blood and organ donation: Health impact, prevalence, correlates and interventions.**

Journal:	<i>European Health Psychology Society</i>
Manuscript ID	GPSH-2018-0582.R3
Manuscript Type:	Psychology and Health
Keywords:	Blood Donation, Organ Donation, Altruism, Reciprocity

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Manuscripts

Ferguson E, Murray C & O'Carroll RE (2019) Blood and organ donation: health impact, prevalence, correlates, and interventions. *Psychology and Health* p. 32.  
<https://doi.org/10.1080/08870446.2019.1603385>

## Blood and organ donation: Health impact, prevalence, correlates and interventions.

### Abstract

**Objective:** Without a supply of blood, health services could not meet their clinical needs. Similarly, organs for transplantation save and transform lives. Donations are acts of generosity that are traditionally seen as altruistic, and accordingly, interventions to recruit and retain blood and organ donors have focused on altruism. We review the predictors, prevalence and correlates of these two behaviours, how effective interventions have been, and draw common themes. **Design:** Narrative review. **Results:** We highlight that both recipients and donors benefit, and as such neither blood nor organ donation is purely altruistic. We also highlight health problems associated with both types of donation. In evaluating interventions, we highlight that a move to an opt-out default for organ donation may not be the simple fix it is believed to be and propose effective interventions to enhance the opt-in default (e.g. social media updates). We show that incentives, text messaging, feedback and a focus on prosocial emotions (e.g., 'warm-glow', 'gratitude') may be effective interventions for both blood and organ donation. Interventions designed to reduce fainting (e.g., water pre-loading) are also effective for blood donation. **Conclusions:** We conclude that affect is key to understanding both types of donation and in designing effective interventions.

## Definitions

### What is Blood and Organ Donation?

People's health is influenced, in part, not only by their own behaviour (e.g., diet) but also by the behaviour of others. Some aspects of people's behaviour negatively impacts other's health (e.g., passive smoking), while other aspects have dramatic life changing benefits. Such life changing benefits are exemplified by blood and organ donation. Blood and blood products are derived from (1) *whole* blood donations (i.e., giving 450mls of blood), or (2) *apheresis* donations (e.g., where blood is drawn, platelets and plasma extracted, and the blood replaced in the donor minus these products). Organs similarly come from two avenues of donation: *posthumous* and *living*. Living donations are further divided into *directed* donation towards a family member, and *non-directed* (so called 'altruistic') donation towards a stranger (Table 1). All forms of blood and organ donation are traditionally viewed as altruistic.

However, how strong is the evidence for the claim of altruism?

**Altruism – Behavioural Definition:** For all types of blood and organ donation, people give voluntarily, without personal gain, at some personal cost, to help a stranger in need (Ferguson, 2015; Ferguson & Lawrence, 2015; Ferguson & Masser,

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3  
4 2018; Steinberg, 2010). Specifically, whole blood and apheresis donors give blood  
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7 voluntarily to benefit a stranger in need, but also pay a cost in terms of time, effort,  
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10 blood loss, and undergoing a medical procedure. Posthumous organ donation  
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13 occurs after death. Under an opt-in system (see later) there may be some emotional  
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16 cost to registering on the organ donor register (ODR), as it forces the individual to  
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18  
19 confront their own mortality and bodily integrity (Morgan, Miller & Arasaratnam, 2002;  
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21  
22 Morgan, Stephenson, Harrison, Afifi & Long, 2008). Living organ donors can donate  
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25 a kidney or a lobe of either their liver or lung. This incurs significant cost in terms of  
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28 medical procedures, loss of an organ or part of an organ, and pain and recovery  
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31 from surgery. For directed organ donation, there may be additional costs in terms of  
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34 social interactions with relatives where the donor may feel coerced or obliged to  
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36  
37 donate (Gill & Lowes, 2008; Sharp & Randhawa, 2014)<sup>1</sup>. *Evolutionary biology*  
38  
39  
40 defines altruism as a behaviour that increases the fitness of the recipient (i.e., long-  
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42  
43 term survival and fecundity) at a cost to the donor's fitness (Bshary & Bergmüller,  
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45  
46 2008; Sober & Wilson, 1998). Behaviourally, all types of blood and organ donation fit  
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59 <sup>1</sup> There may also be an additional cost as in some cases the donor finds out that they are not  
60 actually related to their relative.

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4 this definition. However, while behaviourally an act may appear altruistic, it may not  
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6  
7 be motivated exclusively by the needs of others (Sober & Wilson, 1998).  
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### 10 11 **Altruism – Motivational Definition and Considerations: *Psychological altruism***

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14  
15 focuses on the motivations underlying helping behaviour (Sober & Wilson, 1998).  
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17  
18 Motivational definitions of altruism across economics, psychology and philosophy  
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20  
21 converge on the idea that *pure altruism* is either a preference, or an ultimate desire,  
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24  
25 to maximize the welfare (utility) of others, by reducing their suffering, at a personal  
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27  
28 cost, without personal benefit (Andreoni, 1990; Batson, 1991; Nagal, 1970). So, are  
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30  
31 blood and organ donors motivated by *pure altruism* or is there some *personal*  
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35  
36 *benefit*?  
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40 Ferguson (2015a) suggested a framework to understand and model these  
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43 motivations that maps the mechanisms of altruism (MOA) derived from psychology,  
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45  
46 economics, biology, sociology, and philosophy (e.g., Andreoni, 1990; Batson, 1991;  
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48  
49 Fehr & Fischbacher, 2004a, 2004b; Fehr & Schmidt, 1999; Nowak, 2006) onto blood  
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53 and organ donor motivations, preferences and behaviour. Drawing on the MOA  
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4 approach, behavioural economic analyses<sup>2</sup> of blood and organ donor preferences

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6  
7 has revealed that both are not purely altruist (Ferguson, 2012a; Ferguson, 2015;

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9  
10 Ferguson & Lawrence, 2018; Ferguson, Zhao, O'Carroll & Smillie, 2018). Rather

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12  
13 blood donors are motivated by a general prosocial preference towards 'warm-glow'

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15  
16 (Ferguson, Farrell & Lawrence, 2008; Ferguson, Taylor, Keatley, Flynn & Lawrence,

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18  
19 2012a). Warm-glow describes the feelings of positive affect that arise as a

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21  
22 consequence of helping (Andreoni, 1990, 1995). Furthermore, Ferguson, Atsma, de

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25 Kort, and Veldhuizen (2012) identified a preference in blood donors they termed

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27  
28 '*reluctant altruism*'. Reluctant altruists help because they do not trust others to help.

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31 This is particularly the case in a context like blood donation where 96% free-ride on

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33  
34 the generosity of the 4% of the eligible population who donate blood at any one time.

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37 The idea of reluctant altruism further suggests that blood donors are more likely to

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40 act when they perceive others as acting unfairly. Consistent with this, blood donors

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<sup>2</sup> The MOA approach recommends that behavioural economic games are used to assess these mechanism so as to avoid social desirability effects when simply asking people why they donate blood or register to be an organ donor (Ferguson 2015a; Ferguson & Lawrence, 2015).

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4 have been shown to have an increased tendency to punish unfairness (Ferguson &  
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7  
8 Lawrence, 2018).  
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11 While for some there may be emotional costs to signing the organ donor register  
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14 (Morgan et al., 2002, 2008), as the donor is deceased, the actual personal physical  
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16  
17 cost for posthumous organ donation is zero. This has led some to question its pure  
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19  
20 altruistic nature (Moorlock, Ives & Draper, 2014). Ferguson et al. (2018) reasoned  
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22  
23 that if this were the case, organ donors should have a preference for costless  
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25  
26 helping in general. Consistent with this reasoning, in a series of economic games to  
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28  
29 assess costless and costly helping, organ donors gave more generously in a  
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31  
32 costless game. Thus, some people may be drawn to posthumous organ donation  
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34  
35 due to its relative costless nature.  
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42 Directed living donors may feel coerced or obliged to donate to loved ones, which  
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45 undermines the voluntary nature of the behaviour (Gill & Lowes, 2008; Lennerling et  
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47  
48 al., 2003). The non-directed donor also may gain personal benefits in terms of pride,  
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51 admiration by others or self-esteem (Roff, 2007). In both cases, therefore, the notion  
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54 of pure altruism is undermined.  
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4 Thus, we can see that all forms of blood and organ donation may be better  
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6  
7 described as acts of impure altruism.  
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## 10 11 **Impact of Blood and Organ Donation** 12

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14 For blood and organ donation there are impacts both on the donor (or their  
15  
16 family) as well as the recipient, as discussed below.  
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### 20 21 **Blood Donation** 22

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26 **Impact on the Recipient:** Health services could not operate without a continual  
27  
28 supply of blood. This is used to treat a wide range of illnesses and disease  
29  
30 processes. For example, from whole blood, red blood cells, among other things, are  
31  
32 used to treat anaemia, sickle cell disease, thalassaemia, blood loss following surgery  
33  
34 and trauma in child-birth, as well as in palliative care. White cells are used to treat  
35  
36 immunodeficiency conditions. platelets to treat clotting deficient conditions (e.g.,  
37  
38 leukaemia) and immunoglobins and albumin, derived from plasma, to treat  
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40 infections, as well as kidney and liver disease.  
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54 **Impact on the Donor:** Both positive and negative health effects have been  
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56 reported for donors. There is increasing evidence that whole blood donation may  
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4 result in long-term iron deficiency (Brittenham, 2011; Di Angelantonio et al., 2017).  
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7 Whether or not this is of clinical significance and its effects on long-term health are  
8  
9  
10 yet fully determined. There are also reported health benefits of donating blood with  
11  
12  
13 respect to: (1) reduced mortality (Ullum et al., 2015; Vahidnia et al., 2013), (2) better  
14  
15  
16 mental health in young donors and physical health in older donors (Rigas et al.,  
17  
18  
19 2017), and (3) reduced risk of myocardial infarction (Salonen, Tuomainen, Salonen,  
20  
21  
22 Lakka & Nyysönen, 1998). However, there is a potential *selection bias* (the '*healthy*  
23  
24  
25 *donor effect*') in operation as blood donors are a self-selected healthier group  
26  
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31  
32 (Atsma, Veldhuizen, Verbeek, de Kort & de Vegt, 2011). Yet even after controlling for  
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34  
35 the 'healthy donor effect,' there is still evidence of reduced mortality (Ullum et al.,  
36  
37  
38 2015) and better self-reported health (Atsma et al., 2011) in blood donors, which  
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42 may reflect healthier lifestyles amongst blood donors (Atsma et al., 2011).  
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## 46 Organ Donation

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50 **Impact on the Recipient:** Advances in transplant surgery and post-surgical  
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53 medical care mean that post-transplant outcomes for patients are usually very good  
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57 (National Health Service Blood and Transplant [NHSBT], 2017). However, there  
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4 currently exists a global shortage of organs for transplant, significantly impairing the  
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7 health and well-being of those awaiting donated organs. In 2018 in the US more than  
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10 114,000 people were awaiting an organ transplant, around 20 of whom died every  
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13 day (organdonor.gov), and in the UK, more than 6,000 people were on the transplant  
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16 waiting list, approximately three of whom died every day (NHSBT;  
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21 <https://www.nhsbt.nhs.uk>).

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25 **Impact on the Donor:** For the posthumous donor there is no direct impact, but  
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27  
28 there is impact for the relatives of the donor, who will be approached (both under  
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31 opt-in and soft opt-out defaults) by a specialist nurse for organ donation (SNOD) to  
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33  
34 consent to their relatives' organs being used for transplant. This can be a very  
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37 distressing time for family members who are coming to terms with the death of a  
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40 relative and are then asked for consent for their relatives' organs to be removed and  
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46 donated.

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50 For living donation there are significant health impacts on the donor that arise from  
51  
52 the removal of the organ, not just in terms of the surgery and immediate recovery, but also in  
53  
54 terms of long-term health consequences. For example, persistent post-surgical pain is  
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56 reported by over one quarter of living liver donors 12-months later (Holtzman et al., 2014).  
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## Prevalence of Blood and Organ Donation

### Blood Donation

**How many donate blood?** Across Europe about 40% of people say that they have donated whole blood at some point in their lives

([http://ec.europa.eu/commfrontoffice/publicopinion/archives/ebs/ebs\\_333b\\_en.pdf](http://ec.europa.eu/commfrontoffice/publicopinion/archives/ebs/ebs_333b_en.pdf)).

However, while blood and blood products are available to all, at any one time only 3-4% of the eligible UK population donate blood. This figure is consistent across western style donation systems. At present, in the UK, whole blood donors can donate up to 4 times a year if male, and 3 times if female, while apheresis donors can donate up to 24 times a year.

**How many donors are needed?** Whole blood has a shelf life of 35 days and the UK National Health Service (NHS) requires 31 units of blood per 1000 of the population, per annum, to provide the efficient and safe delivery of health care (Blood 2020, NHSBT Annual Review 2012-13). To meet these healthcare demands, recruiting new donors, especially young donors, is an ongoing issue, with nearly 200,000 new donors required by the UK NHS yearly. New donors, compared to repeat donors, have a higher risk of fainting and higher incidence of red cell antibodies for transfusion-transmittable-infections (TTIs) (Lucky et al., 2013; Zou et al., 2012). Thus, converting 'new donors' into 'repeat donors' constitutes a significant saving in terms of recruitment costs, improved donor safety, and reduce waste in terms blood that cannot be subsequently used. However, the conversion rate from 1<sup>st</sup> to repeat donations is low, with only 7.2% making three subsequent donations (Schreiber et al., 2005), thus interventions to enhance conversion rates are needed.

While there has been a steady reduction in the demand for red cells across the world, due to better cell-salvage or operative procedures, this does not mean that recruiting new

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4 donors and retaining repeat donors is not an on-going issue. Future shortfalls in blood  
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6 supplies are predicted as the population ages (requiring more transfusions), the current donor  
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8 pool ages out, and younger donors not being recruited to replace lost donors (Carter et al.,  
9  
10 2011; Greinacher & Fendrich, 2010; Greinacher, Fendrich, Alpen, & Hoffman, 2007;  
11  
12 Greinacher, Fendrich, & Hoffman, 2010).

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14  
15 **Who is needed?** With the genomic revolution, more detailed blood typing and  
16  
17 matching offers the possibility of improved treatment options that require matching specific  
18  
19 donors with particular blood types and antigens to specific recipients. Thus, recruitment  
20  
21 becomes targeted on specifically needed donors, rather than an ‘all-comers model’. This is  
22  
23 exemplified by a world-wide need to recruit donors from minority groups (van Dongen,  
24  
25 Mews, de Kort, & Wagenmans, 2016). A particular need is to encourage donors from Black,  
26  
27 Asian and Minority Ethnic (BAME) backgrounds to improve the treatment of certain  
28  
29 conditions (e.g., sickle cell disease: SCD), that have a higher prevalence in BAME  
30  
31 communities (Shaz, Zimring, Demmons, & Hillyer, 2008). SCD requires repeat transfusions  
32  
33 and are most effectively delivered with phenotype-matched red blood cells for the Ro Kell  
34  
35 antigen to reduce haemolytic transfusion reactions (Shaz et al., 2008). The Ro Kell type has a  
36  
37 much higher prevalence in BAME communities at approximately 55% in black Africans,  
38  
39 43% in black Caribbean, 17-24% in mixed race and 2% in white Caucasians, making  
40  
41 phenotypic matching easier if the number of BAME donors increases. However, of the 4% of  
42  
43 the UK population who donate, only 4% are from BAME groups (NHSBT Annual Review  
44  
45 2012-13). The UK NHSBT needs to recruit 40,000 BAME donors per year, with the current  
46  
47 number approximately 15,000 ([https://nhsbtdeb.blob.core.windows.net/umbraco-assets-](https://nhsbtdeb.blob.core.windows.net/umbraco-assets-corp/4481/nhsbt-strategic-plan-2017-2022.pdf)  
48  
49 [corp/4481/nhsbt-strategic-plan-2017-2022.pdf](https://nhsbtdeb.blob.core.windows.net/umbraco-assets-corp/4481/nhsbt-strategic-plan-2017-2022.pdf)). Thus, interventions to encourage BAME  
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51 donors is a pressing clinical need.  
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## Organ Donation

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4 **How many donate?** Currently, approximately 38% of the population are registered  
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6 posthumous donors on the UK opt-in ODR. Furthermore, families/next of kin refuse to  
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8 consent in 34% of requests for organs, often over-riding the wishes of potential donors  
9  
10 ([http://www.organdonation.nhs.uk/](http://www.organdonation.nhs.uk/statistics) statistics, NHSBT 2017-2018). This, and other factors  
11  
12 (e.g., health of the donor's organs) means that only a very small proportion of deaths convert  
13  
14 to organs donated. For example, in the UK in 2017-2018 from 600,000 deaths there were  
15  
16 7,281 potential donors which then reduced to 6,038 eligible donors. Of these, only 2,233 had  
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18 actively opted-in and this eventually resulted in 1,574 actual donors (NHSBT, 2017-2018).  
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22 **Who are needed?** Ethnic minority groups represent 11% of the UK population, but  
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24 only 7% of deceased organ donors (NHSBT, 2017-2018), and rates of consent from family  
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26 members are lower than for white family members. As with blood donation there is an urgent  
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28 need to engage BAME communities and explore reasons for the lower consent rates.  
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## 32 **Correlates of Blood and Organ Donation**

### 33 **Blood Donation**

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36 **Theory of Planned Behaviour (TPB):** TPB is the theoretical model most often  
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38 applied to blood donor behaviour (Bednall, Bove, Cheetham & Murray, 2013;  
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40  
41 Ferguson, 1996). Within the TPB, intentions are the proximal predictor of behaviour,  
42  
43 with intentions predicted by (1) attitudes, (2) subjective norms (i.e., people who are  
44  
45 important to the donor approve of blood donation), and (3) perceived behavioural  
46  
47 control (PBC: i.e., feeling able to donate despite possible barriers). Attitudes can be  
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49 further split in to affective (i.e., anticipated and current positive or negative emotional  
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4 responses) and cognitive (i.e., pros and cons) (Trafimow & Sheeran, 1998). With  
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7 respect to blood donation, the TPB has been extended to include *descriptive norms*  
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10 (i.e. the perception of how many others perform the behaviour), self-efficacy, and  
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12  
13 donor role identity. Prosocial factors including *pure altruism*, *personal moral norms*  
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15  
16 (i.e. donors' beliefs that they *ought to help*), and *warm-glow* (termed 'satisfaction with  
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19 self' by Bednall et al., 2013) have also been added. Bednall et al.'s (2013) meta-  
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22 analytic review showed that intentions are the strongest predictor of blood donor  
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24  
25 behaviour ( $r = .362$ ), followed by PBC ( $r = .311$ ), attitudes ( $r = .216$ ) and subjective  
26  
27  
28 norms ( $r = .165$ ). Self-efficacy ( $r = .352$ ) and role identity ( $r = .232$ ) were also  
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30  
31 significant predictors of behaviour from the extended TPB. In terms of prosocial  
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33  
34 factors, personal moral norms ( $r = .188$ ) and warm-glow ( $r = .097$ ) both predicted  
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37 actual donations, but pure altruism did not ( $r = -0.015$ ) (Bednall et al., 2013; see also  
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46 Ferguson, 1996).

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49 **Transtheoretical Model (TTM):** Blood donors potentially progress through a  
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52 'donor career,' cycling through repeat donations (Ferguson, 1996; James &  
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56 Matthews, 1993). Starting as non-donors, they then become 1<sup>st</sup> time/novice donors,  
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4 and if not deferred<sup>3</sup>, return to become repeat donors. This career structure makes  
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6  
7 the TTM a promising theoretical framework to describe the donor career and the  
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10 types of intervention that may be appropriate at each stage (Ferguson & Chandler,  
11  
12  
13 2005). The TTM consists of two main factors: *stages* and *processes* of change  
14  
15  
16 (Prochaska, DiClemente & Norcross, 1992). The model outlines five *stages* to  
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18 progress through: (1) 'pre-contemplation' where individuals have no intention to  
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21 change, (2) 'contemplation' where individuals are aware of the reasons to change  
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24 and may weigh up the pros and cons, (3) 'preparation' where individuals are  
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27 intending to take action in the next month, (4) 'action' where individuals have  
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29  
30 successfully achieved the desired behaviour, and (5) 'maintenance' where the  
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33 desired behaviour is maintained for at least six months. Ten basic *processes of*  
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36 *change* (e.g., consciousness raising) are proposed to facilitate the transition from  
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39 one stage to the next (Prochaska & DiClemente, 1982), and can be explained by two  
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41  
42 higher order factors with respect to blood donation (Ferguson & Chandler, 2005): (1)  
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53 *experiential processes* (e.g., cognitive and emotional strategies including *dramatic*  
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58 <sup>3</sup> A person may be *permanently* (can never give blood) or *temporally* (can give blood after a designed time  
59 window) deferred from blood donation. Permanent deferrals occur if, for example, the person has had a blood  
60 transfusion (or blood products) since 1st January 1980. Temporary deferrals can be on grounds of anaemia,  
travel abroad, sexual behaviour, tattoos, or intravenous drug taking.

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4 *relief* i.e. “Dramatic portrayals about the consequences of a lack of blood donors upset me”,  
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6 *social liberation* i.e. “I know I'd feel better about myself if I was a blood donor”), and (2)  
7  
8  
9 *behavioural processes* (e.g., activity based strategies including *stimulus control* i.e. “I  
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11  
12 leave stickers / letters about blood donation in prominent places around my home” and  
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14  
15 *counter-conditioning* i.e. “When giving blood I try to think of something else”). Ferguson  
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18 and Chandler (2005) further showed that the number of previous donations was  
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22 positively predicted by *behavioural* processes and negatively predicted by  
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25  
26 *experiential* processes. Stage and process factors became uncorrelated as donors  
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29 became more experienced, suggesting that helping donors develop behavioural  
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32 strategies would be beneficial. Further support for the psychometric validity of the  
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TTM with respect to blood donation has been reported (Amoyal et al., 2013; Burditt,  
et al., 2009).

**Prosocial Emotions:** Ferguson and Masser (2018) suggested that prosocial  
emotions are central to understanding blood donor behaviour, and used Haidt's  
(2003) concept of ‘families of moral emotions’ to categorize these. They argued that  
*warm-glow* (i.e. happiness) and *pride* (within the family of self-conscious emotions),  
are key emotions, with warm-glow predicting donor return (Bednall et al., 2013;



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4 Ferguson et al., 2008; Piliavin & Callero, 1991), and more likely to be reported by  
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6  
7 experienced donors (Ferguson et al., 2012b). Ferguson and Flynn (2016) have  
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9  
10 shown, theoretically, that warm-glow can also be anticipated, making it equivalent to  
11  
12  
13 the concept of an anticipated affective reaction in the prosocial context. This is  
14  
15  
16 important as anticipated positive affective reactions have been shown to be  
17  
18  
19 significant predictors of blood donor behaviour (Conner, Godin, Sheeran & Germain,  
20  
21  
22 2013).  
23  
24  
25  
26  
27

28 *Pride* can be divided into *hubristic* (linked to arrogance and conceit), and  
29  
30  
31 *authentic* (linked to achievement) (Tracy & Robins, 2007). Authentic pride is linked to  
32  
33  
34 both prosociality (Tracy & Robins, 2007; Weiner, 1985) and warm-glow (Saito, 2015)  
35  
36  
37 generally, and recent evidence shows that plasma donors report authentic pride as a  
38  
39  
40 function of giving 'more' than whole blood donors (Bove, Bednall, Masser & Buzza,  
41  
42  
43 2011).  
44  
45  
46  
47  
48

49 *Shame* and *guilt* are also self-conscious emotions referring to the self-  
50  
51  
52 representation of personal wrong-doing. Guilt is private and behaviour-focused and  
53  
54  
55 shame public and self-focused (Amodio, Devine & Harmon-Jones, 2007). People are  
56  
57  
58 motivated to avoid the guilt of not acting prosocially or the shame of acting selfishly  
59  
60

1  
2  
3  
4 (Saito, 2015), and both emotions lead to increased prosociality (Allpress, Brown,  
5  
6  
7 Giner-Sorolla, Deonna, & Teroni, 2014). Guilt has been identified as a key blood  
8  
9  
10 donor motivation (France, Kawalsky, France, Himawan, Kessler, & Shaz, 2014), and  
11  
12  
13 one that is linked to donating blood in emergency contexts (Chliaoutakis, Trakas,  
14  
15  
16 Socrataki, Lemonidou, & Papaioannou, 1994). The concept of *anticipated regret* at  
17  
18  
19 not donating is clearly linked to guilt and shame, with evidence showing that  
20  
21  
22  
23  
24  
25 anticipated regret is a strong, positive predictor of both intentions to donate (Godin, et  
26  
27  
28 al., 2005) and actual donation (Godin, Conner, Sheeran, Bélanger-Gravel, &  
29  
30  
31  
32 Germain, 2007).

33  
34  
35 The 'other-praising emotions' of *gratitude*, *awe* and *elevation* are all potential  
36  
37  
38 important predictors of blood donation. Of these, gratitude is likely to be significant.  
39  
40  
41  
42 There is extensive evidence that gratitude is linked to prosociality and both direct and  
43  
44  
45 indirect reciprocity (Ma, Tunney & Ferguson, 2017). Indeed, reciprocity towards the  
46  
47  
48 blood service and the donor, is a frequently cited motivation by blood donors (Bendall  
49  
50  
51  
52 & Bove, 2011).

53  
54  
55  
56 **Fear and Anxiety:** The emotions of fear and anxiety associated with donating  
57  
58  
59 blood have been shown to impact negatively on return rates by increasing the  
60

1  
2  
3  
4 chances of the donor fainting (Chell, Waller & Messer, 2016; Meade, France, &  
5  
6  
7 Peterson, 1996; Viar, Etzel, Ciesielski & Olatunji, 2010), or directly by fear and anxiety  
8  
9  
10 making people less willing to donate in the first place (Bednall & Bove, 2011).

11  
12  
13  
14 **Vasovagal Reactions:** A consistent strong predictor of a donor not returning is  
15  
16  
17 the experience of feeling faint, or actually fainting (Ditto & France, 2006; France et  
18  
19  
20 al., 2014a; France et al., 2013; France, Rader & Carlson, 2005), which results in a  
21  
22  
23  
24  
25 20% and 33% reduction in return rates amongst first time and experienced donors  
26  
27  
28 respectively (France et al., 2005 see also Bednall et al., 2013). Effects of fainting on  
29  
30  
31 return rates are not just confined to those fainting, but are also seen in those  
32  
33  
34  
35 observing others faint (Ferguson & Bibby, 2002).

36  
37  
38  
39 **The Functional Model of Volunteer Behaviour:** Omoto and Snyder (1995) and  
40  
41  
42 Clary et al. (1998) identified six functional motivations for volunteerism (Table 2).  
43  
44  
45 Applied to blood donation more experienced donors express motivations that reflect  
46  
47  
48 avoidance of guilt at not donating, and strengthening of social bonds (Alfieri, Paolo,  
49  
50  
51  
52 Marta, & Saturni, 2016; Paolo, 2013; Paolo, Alfieri, Marta, & Saturni, 2015),  
53  
54

55  
56 **Self Determination Theory (SDT):** Self-determination theory describes people  
57  
58  
59 as motivated along a continuum from extrinsic to intrinsic motivation (Ryan & Deci,  
60

1  
2  
3  
4 2000). Extrinsic motivation has four components that increase in personal autonomy  
5  
6  
7 from 'external regulation' (motivated by rewards), to 'introjected regulation'  
8  
9  
10 (avoidance of guilt), to 'identified regulation' (personally valued behaviour) to  
11  
12  
13 'integrated regulation' (behaviours consistent with a person's life goals). Pure intrinsic  
14  
15 motivations concern behaviours that are enjoyable and satisfying. France, Kawalsky  
16  
17  
18 and colleagues (2014) developed the Donor Identity Survey that assesses the  
19  
20  
21 fundamental motivation of SDT for blood donation. Table 2 shows how the  
22  
23  
24  
25 motivations from SDT, the Functional Model of Volunteer Behaviour and MOA align  
26  
27  
28 with respect to prosociality. For example, intrinsic motivation from SDT and the  
29  
30  
31 enhancement motivation from the functional approach all assess warm-glow, as do  
32  
33  
34 affective attitudes. To avoid a 'jangle fallacy' (where by the same construct is given  
35  
36  
37 different names) in the area of prosociality, we propose that they should all be termed  
38  
39  
40  
41  
42  
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44  
45  
46  
47  
48 warm-glow as this is a fundamental MOA.

49 **Personality:** Bekkers (2006) showed that while trait helpfulness (i.e., being  
50  
51  
52 helpful and cooperative) predicted blood donation, traits of warmth (akin to  
53  
54  
55 agreeableness) and empathy did not. The lack of significant association between  
56  
57  
58  
59  
60 both traits of agreeableness and empathy with blood donation has also been

1  
2  
3  
4 reported by others (Ferguson, 2008; Ferguson et al., 2008; Steele, et al., 2008). This  
5  
6  
7 lack of association with prosocial traits, in conjunction with the observation that  
8  
9  
10  
11 repeat blood donation follows a career path, led Ferguson (2008) to reason that trait  
12  
13  
14 conscientiousness (linked to being organized) should predicted repeat donation.  
15  
16  
17  
18 However, while Ferguson (2008) shows that conscientiousness predicts the  
19  
20  
21 frequency and rate of past donations, the link between conscientiousness and  
22  
23  
24 reported future blood donation has not be established (see White, Poulsen & Hyde,  
25  
26  
27  
28 2017).

31  
32 **Deferrals:** A person may be *permanently* (can never give blood) or *temporarily*  
33  
34  
35 (can give blood after a designed time window) deferred from blood donation.  
36  
37  
38  
39 Temporary deferrals have a medium sized negative effect on return rates (Bednall et  
40  
41  
42 al., 2013).

45  
46 **Donation Context:** The experience the donor has while donating blood may  
47  
48  
49 greatly influence subsequent donor behaviour. Ferguson (1996) showed that longer  
50  
51  
52 waiting times have a large negative effect on return rates ( $r = .417$ ), while satisfaction  
53  
54  
55  
56 with the quality of services has a positive effect on both return rates ( $r = .092$ ) and  
57  
58  
59 intentions to return ( $r = .290$ ) (Bednall et al., 2013).  
60

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4           **Donor Experience (past behaviour):** The number of previous donations has an  
5  
6  
7 important influence on donor return rates, intentions and motivations. More  
8  
9  
10 experienced donors, especially those who have made five or more donations, exhibit  
11  
12  
13 higher return rates (Bednall et al., 2013; Ferguson, 1996; Ferguson & Chandler,  
14  
15  
16  
17  
18 2006). However, the link between past and future blood donor behaviour is complex  
19  
20  
21 and best represented by a quadratic inverted U shaped function, which is positive up  
22  
23  
24 to 60 previous donations, and then levels off and becomes negative (Ferguson &  
25  
26  
27  
28 Bibby, 2002). Similarly, past behaviour influences the effects of intentions on future  
29  
30  
31 behaviour, such that the intentions-behaviour link is significant and positive for novice  
32  
33  
34 donors (4 or less donations), and not significant for experienced donors (5+  
35  
36  
37  
38  
39 donations: Ferguson & Bibby, 2002; Sheeran et al., 2017). Indeed, an inverted U  
40  
41  
42 shaped quadratic function also explains this link between donor intentions and  
43  
44  
45 behaviour, with intention predictive up to a certain point of experience, and then  
46  
47  
48 dropping off (Sheeran et al., 2017). Experienced donors are also less likely to be  
49  
50  
51 adversely affected by temporary deferrals and more positively motivated by  
52  
53  
54 anticipated regret (Bednall et al., 2013).  
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## Organ Donation

**Models of Organ Donation:** A variety of models have been proposed to explain organ donor behaviour. Many focus on social cognition models (e.g. TPB) and have been recently reviewed by Falomir-Pichastor, Berent and Pereira (2013).

The authors conclude that in addition to attitude and intention, 14 additional determinants of organ donation can be identified. Distal predictors of attitude and intention included demographic factors, cultural differences, religiosity, social insertion and personality factors. Proximal predictors of organ donation included behavioural beliefs, normative beliefs, self-efficacy, past behaviour, direct experience, affective reactions, social representations, identity and moral norms. Hyde, Knowles and White (2013) tested the utility of an extended TPB model and found that it explained 75% of the variance in organ donation intentions. Significant predictors in the final model included attitude, subjective norm, self-efficacy, self-identity and in-group altruism. They concluded that future donation strategies should foster a perception of self as the type of person who donates and address preferences to donate organs to in-group members only.

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3  
4 The IIFF model (Siegel et al., 2010) propose that four factors are key to  
5  
6  
7 donation: (1) an *immediate* and complete registration opportunity ('ICRO' "a card in  
8  
9  
10 the hand"), (2) *information*, (3) *focused* engagement and (4) *favourable* activation.  
11  
12  
13  
14 Alvaro, Siegel and Jones (2011) tested one component of the IIFF, the ICRO, and  
15  
16  
17 found that simply providing an ICRO significantly increased organ donor registrations  
18  
19  
20  
21 (see section below on community-based interventions).  
22  
23  
24

25  
26 Quick, Anker, Feeley and Morgan (2015) compared three models of organ  
27  
28 donation behaviour – (1) Bystander Intervention Model (BIM) which emphasises  
29  
30  
31 bystanders' situational interpretation with respect to intervening to help others in  
32  
33  
34 need, (2) Vested Interest Theory (VIT) which positions vested interest as a  
35  
36  
37 moderator of the attitude-behaviour relationship, and (3) The Organ Donation Model  
38  
39  
40 (ODM) which was developed to take into account affective attitudes. They found that  
41  
42  
43 VIT accounted for most variance in organ donation registration intentions.  
44  
45  
46  
47  
48  
49

50 **Attitudes of Potential Donors:** Negative affective attitudes have been identified  
51  
52  
53 as important barriers to organ donation (Morgan et al., 2008; O'Carroll, Dryden,  
54  
55  
56  
57 Hamilton-Barclay, & Ferguson, 2011, O'Carroll, Foster, McGeechan, Sandford, &  
58  
59  
60



1  
2  
3  
4 Ferguson, 2011) and shown to be stronger predictors than TPB variables (Morgan et  
5  
6  
7 al., 2008; O'Carroll, Dryden, et al., 2011; O'Carroll, Foster, et al., 2011) or knowledge  
8  
9  
10 (Morgan et al., 2008). These affective barriers include concerns that clinicians may  
11  
12  
13 not try as hard to save the potential donor ("medical mistrust"), disgust at the thought  
14  
15  
16 of donation ("ick factor"), that registering in some way hastens one's death ("jinx  
17  
18  
19 factor"), and discomfort at the thought of one's body being operated on for organ  
20  
21  
22 retrieval ("body integrity").  
23  
24  
25  
26  
27  
28

29 **Personality:** Relationships between the 'Big Five personality traits' (Costa, &  
30  
31 McCrae, 1992; Goldberg, 1993) and organ donation behaviour have been explored,  
32  
33  
34 and the prosocial trait of agreeableness and its facets (e.g., cooperation, trust,  
35  
36  
37 empathy) have been linked to organ donor behaviour and intentions. For example,  
38  
39  
40 individuals registered to donate some specific, but not all organs, have been found to  
41  
42  
43 have higher warmth (agreeableness) (Bekkers, 2006), and higher agreeableness  
44  
45  
46 scores have been associated with positive organ donation attitudes and intentions  
47  
48  
49 (Hill, 2016). Altruism (a facet of agreeableness) has been associated with  
50  
51  
52  
53 possession of a signed organ donor card (Kopfman & Smith, 1996), but was not  
54  
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57  
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59  
60

1  
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3  
4 directly associated with Singapore residents' willingness to donate (Lwin, Williams &  
5  
6  
7 Lan, 2002)<sup>4</sup>, or the organ donor registration status of American students (Hill, 2016).

8  
9  
10 In a meta-analysis, altruism (measured using generic scales that assess low cost  
11  
12  
13 unconditional altruism towards strangers) was associated with an increased  
14  
15  
16  
17 likelihood of organ donor registration (Nijkamp, Hollestelle, Zeegers, van den Borne,  
18  
19  
20 & Reubsaet, 2008). Compassion and empathy (facets of agreeableness) have also  
21  
22  
23  
24 been linked to intentions to donate (Demir & Kumkale, 2013). Thus, unlike blood  
25  
26  
27  
28 donation there seems to be some linkage between unconditional altruism,  
29  
30  
31  
32 empathy/compassion and organ donor registration.

33  
34  
35  
36 **Clinicians' Attitudes Towards Living Donation:** Twenty-eight percent of UK  
37  
38  
39 kidney donations currently come from living donors (NHSBT, 2017/2018). There  
40  
41  
42  
43 exists wide variation in non-directed living donation rates across transplant centres  
44  
45  
46  
47 which may reflect clinicians' attitudes to non-directed donors, which are polarized  
48  
49  
50  
51 between seeing them as extremely altruistic or psychiatrically disturbed (Henderson  
52  
53  
54 et al., 2003). However, comparisons of directed versus non-directed UK kidney  
55  
56  
57

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58  
59  
60 <sup>4</sup> Singapore operates a priority system, with those on the organ donation register given greater priority to organs if needed. This powerful default is likely to over-ride other factors.

1  
2  
3  
4 donors have found no difference in psychiatric history, personality, or current  
5  
6  
7 depression, anxiety, stress, self-esteem, or well-being. Importantly, no differences in  
8  
9  
10 donors' physical outcomes were found and non-directed donors recovered from the  
11  
12  
13 operation slightly quicker (Maple et al., 2014).  
14  
15  
16

## 17 **Intervention to Promote Blood and Organ Donation**

### 18 **Blood Donation**

19  
20  
21  
22  
23 As there is a clear blood donor career, we explore interventions targeted prior  
24  
25  
26 to donation (to recruit and retain donors), as well as during donation (donor safety  
27  
28  
29 and satisfaction) (Ferguson, et al., 2007; van Dongen, 2015).  
30  
31  
32  
33

34 **Interventions for Recruitment and Retention:** A number of techniques have  
35  
36  
37 been used to enhance both recruitment and retention such as use of reminders  
38  
39  
40 (letters, texts, emails), social motivational interventions to enhance positive attitudes  
41  
42  
43 of altruism (usually messages and slogans such as 'do something amazing, save a  
44  
45  
46 life'), and techniques such as 'foot-in-the-door' (i.e. asking for a small commitment to  
47  
48  
49 donate initially, then for a subsequent larger one). A meta-analysis of these  
50  
51  
52 interventions undertaken by Godin et al. (2012) showed that, overall, reminders were  
53  
54  
55 quite effective (OR = 1.91,  $r = .69$ ), as were foot-in-the-door techniques (OR = 1.86,  $r$   
56  
57  
58  
59  
60

1  
2  
3  
4 = .68) and cognitive based social motivations (OR = 2.47,  $r = .77$ ). Godin et al.  
5  
6

7 showed that altruism-based interventions had the largest effect size (OR = 3.89,  $r =$   
8  
9

10 .89). However, while coded as altruism, Ferguson et al. (2007) had previously  
11  
12

13 argued that these 'altruism' based interventions are in fact tapping 'impure' rather  
14  
15

16 than 'pure' altruism.  
17  
18  
19  
20

21 Evidence suggests that feedback on the success of a prosocial act increases  
22  
23

24 the likelihood of subsequent prosocial acts (Smith, Keating & Stotland, 1989). In  
25  
26

27 blood donation, providing text messages to donors saying that their blood has been  
28  
29

30 used, increases return rates by approximately 8% (Gemeilli, Carver, Garmm, Wright  
31  
32

33 & Davison, 2018).  
34  
35  
36  
37

38 Making a plan after donating, indicating when and where the donor's next  
39  
40

41 donation will be ('implementation intention') increases the likelihood of return  
42  
43

44 donations (Godin et al., 2013 & 2014; Wevers, Wigboldus, van den Hurk K, van  
45  
46

47 Baaren, & Veldhuizen, 2015). However, with appointment systems becoming more  
48  
49

50 common, additional interventions are needed to enhance the motivation to return  
51  
52

53 once an appointment has been made. Motivational interviewing is one promising  
54  
55

56 possibility with evidence that a motivational interview increased personal autonomy  
57  
58  
59  
60

1  
2  
3  
4 and intrinsic motivation, with both linked to increased likelihood of making a  
5  
6  
7 subsequent donation (France & France, 2018; France, France, Carlson, Frye, et al.,  
8  
9  
10 2017; France, France, Carlson, Himawan, et al., 2017). Finally, a recent feasibility  
11  
12  
13 study on the use of TTM stages and process tool to recruit blood donor has shown  
14  
15  
16 that such an approach would be acceptable and increase intentions to donate blood  
17  
18  
19  
20  
21 (Robbins et al., 2015).  
22  
23

24  
25 While showing promise, all these interventions focus on “cold” cognition, while  
26  
27  
28 the above review suggests that affect is important. Furthermore, they are all based  
29  
30  
31 on an assumption that blood donors are pure rather than impure altruists. Below,  
32  
33  
34 therefore, we consider some promising avenues for interventions based on affect  
35  
36  
37 and the impure altruistic donor.  
38  
39  
40

41  
42 Evidence shows that *anticipatory* guilt (guilt arising in advance of a future  
43  
44  
45 transgression, which can be avoided), rather than *reactive* guilt (guilt experienced  
46  
47  
48 when a transgression takes place), predicts intentions to donate blood (Renner,  
49  
50  
51 Lindenmeier, Tscheulin, & Drevs, 2013). However, if the activation of guilt is  
52  
53  
54 perceived as manipulative (“if people like you do not donate then there will be  
55  
56  
57 shortages”) it can lead to anger and reactance (Cotte, Coulter, & Moore, 2005). To  
58  
59  
60

1  
2  
3  
4 avoid this problem, Ferguson (2015a) and Ferguson and Lawrence (2015)  
5  
6  
7 suggested a form of message to engender prosocial guilt based on the models of  
8  
9  
10  
11 inequality aversion (Fehr & Schmidt, 1999). Such a message would state: “As  
12  
13  
14 someone in good health, you can help someone whose health is not as good as  
15  
16  
17 yours by donating blood”. There is some initial evidence that this form of message  
18  
19  
20  
21 may be effective (Ferguson, 2015b).  
22  
23  
24

25         As experiencing warm-glow becomes a more salient motivation in  
26  
27  
28 experienced donors, Ferguson (2015a) has argued that promoting warm-glow should  
29  
30  
31 be a more effective intervention for donor retention. Consistent with this, Ferguson et  
32  
33  
34 al. (2008) contrasted a warm-glow appeal with a pure-altruism appeal and showed  
35  
36  
37 that the warm-glow appeal increased willingness to donate in those who committed  
38  
39  
40 to donate blood. Further, interventions that reactivate the feelings of ‘warm-glow’  
41  
42  
43 after donating are also a promising avenue to pursue (Ferguson, 2015). Currently an  
44  
45  
46 RCT is underway with the Australian Red Cross to test this (pre-registered with OSF:  
47  
48  
49 <https://osf.io/r8dca/>).  
50  
51  
52  
53  
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55

56         Similarly, a simple ‘thank-you’ that likely engenders feelings of *gratitude*  
57  
58  
59 should be an effective intervention (Ma et al., 2017) and there is some evidence, in  
60

women, that this is the case compared to an implementation intention or reward

(Myhal, Godin & Dubuc, 2017).

As blood donors can be characterised as impure altruists, financial incentives could be beneficial (Ferguson, 2015). While it has been argued that financial incentives (i.e., 'blood money') may de-motivate ("crowd-out") intrinsically experienced donors (Titmuss, 1970), framing the transaction as a 'social exchange' (i.e., the donor provides a 'gift of life' and the blood service thanks them with a gift), may be effective (Mauss, 1990; Sharp & Randhawa, 2014). This approach has been explored in two ways, either as a (1) 'gift voucher' in return for donation ('*Gift Exchange*': Lacetera, Macis, & Slonim, 2013, 2014) or (2) financial gift that can be donated to another health charity ('*Charity Option*': Mellstrom & Johannesson, 2008; Sass, 2013). The opportunity to help another charity in exchange for donating blood should provide the opportunity to gain *extra warm-glow*. When incentives were given for a pre-donation health check, evidence to-date suggests that a charity option has a neutral effect, while a financial exchange leads to crowding-out in female donors (Mellstrom & Johannesson, 2008). In contrast, when focusing explicitly on a financial 'gift exchange' there is empirical support that donor attendance is proportional to the

1  
2  
3  
4 value of the gift card (Lacetera et al., 2013, 2014). While the financial 'gift exchange'  
5  
6  
7 seems promising, there is no real evidence for any systematic effects of other  
8  
9  
10 financial (e.g., tax relief) and non-financial (including time off work, cholesterol  
11  
12  
13 testing) incentives to donate blood (Chell, Davison, Masser & Jensen, 2018).  
14  
15  
16

### 17 **Interventions During Donation to Enhance Donor Experiences and Health:**

18  
19  
20  
21 How the donor feels or reacts (vasovagal reactions) while donating blood influences  
22  
23  
24 both their intentions and actual return (Bendall et al., 2013). Vasovagal reactions  
25  
26  
27 also have implications for the donor's health at their time of donation. Diverting  
28  
29  
30 attention away from anxiety provoking stimuli can have significant benefits  
31  
32  
33  
34 (Anderson, Baron & Logan, 1991). In the context of blood donation, donors who  
35  
36  
37 prefer avoidant coping strategies were less likely to experience negative reactions  
38  
39  
40  
41 when watching a movie while donating blood, and those who preferred vigilant  
42  
43  
44 coping were neither helped nor harmed by watching the movie (Bonk, France &  
45  
46  
47 Taylor, 2001). Similarly, mixed detrimental and beneficial findings have been  
48  
49  
50 reported for the presence of "easy listening" background music as a function of  
51  
52  
53 donation experience and vigilance coping (Ferguson, Singh, & Cunningham-Snell,  
54  
55  
56  
57  
58  
59  
60 1997).



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3  
4 Repeated, rhythmic contraction of major muscle groups of the arms and legs -  
5  
6  
7  
8 applied muscle tension (AMT) – has been used successfully to treat fainting  
9  
10  
11 reactions in blood and injury phobia (e.g., Ost & Sterner, 1987). AMT has been  
12  
13  
14 applied to prevent negative reactions in blood donors (e.g., Ditto, France, Lavoie,  
15  
16  
17 Roussos & Adler, 2003). Meta-analytic evidence shows that while AMT did not  
18  
19  
20  
21 reduce vasovagal reactions as reported by the phlebotomist, it did result in a  
22  
23  
24 reduction in vasovagal symptoms (*Mean Difference* = -0.07,  $p = .02$ ) (Fisher et al.,  
25  
26  
27 2016). Furthermore, AMT is effective when performed at key points across the  
28  
29  
30  
31 donation process (when the needle is inserted, the needle is removed, and getting  
32  
33  
34 up from the chair) (Thijssen et al., 2018). There is some evidence that AMT increases  
35  
36  
37 intentions to return (*Mean Difference* = 2.87,  $p = .004$ ), but not actual return  
38  
39  
40  
41  
42 behaviour (*RR* = 1.02,  $p = .64$ ).  
43  
44

45  
46 Based on evidence that healthy individuals show increased vascular  
47  
48  
49 constriction and arterial constriction after consuming water (Scott, Greenwood,  
50  
51  
52 Gilbey, Stoker & Mary, 2001), the effect of pre-donation hydration on the experience  
53  
54  
55 of vasovagal reactions has been examined in blood donors (e.g., Newman et al.,  
56  
57  
58 2006). Meta-analysis results show that pre-loading significantly reduces blood donor  
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4 vasovagal reactions as reported by the phlebotomist ( $RR 0.79, p < .0001$ ), as well as  
5  
6  
7 vasovagal type symptoms ( $MD = -0.32, p = .001$ ) (Fisher et al., 2016). There are no  
8  
9  
10 data at present linking water consumption directly to return rates. However, these  
11  
12  
13 techniques may have indirect effects on return rates via vasovagal symptoms and  
14  
15  
16 intentions (France et al., 2013).  
17  
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21 **Interventions Targeted at Specific Groups:** Blood donation agencies face the  
22  
23  
24 need for increased specialization in donor recruitment to meet clinical needs. This is  
25  
26  
27 exemplified, as described above, by the need for increased donations from the  
28  
29  
30 BAME community. In terms of developing targeted recruitment campaigns for BAME  
31  
32  
33 donors, no unique *cultural specific motivating* factor that differentiates BAME  
34  
35  
36 donors/non-donors from non-BAME donors/non-donors has been identified (e.g.,  
37  
38  
39 Burzynski, Nam, & Le Vior, 2016; Tran, Charbonneau, & Valderrama-Benitez, 2013).  
40  
41  
42  
43 Altruism emerges as a motivator across all communities and may offer critical  
44  
45  
46 insights when considered within a cross-cultural perspective. First, BAME  
47  
48  
49 communities conceptualize altruism that focuses on reciprocity *within* the community  
50  
51  
52 rather than helping strangers, which is common in western cultures (Tran et al.,  
53  
54  
55  
56  
57  
58  
59 2013). Second, evidence shows that *lack of trust* in healthcare provision/medical  
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4 mistrust (Guerrero, Mendes de Leon, Evans, & Jacobs, 2015; Kimberly et al., 2013),  
5  
6  
7 and in transfusion services (e.g., Boenigk, Mews & de Kort, 2015; Boulware, Ratner,  
8  
9  
10 Cooper et al., 2002), is an important demotivating factor within BAME communities.  
11  
12  
13  
14 A focus on reducing medical mistrust would, therefore, appear to be a fruitful avenue  
15  
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17  
18 to pursue for interventions in this context.  
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## 22 **Organ Donation**

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24  
25 Interventions for posthumous donation to-date have largely focused around  
26  
27  
28 legislative change (e.g., changing to an opt-out policy or prioritising transplant  
29  
30  
31 candidates who have shown commitment to organ donation: Sallis, Harper, &  
32  
33  
34  
35 Sanders, 2018).  
36  
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39  
40 **Legislative Approaches - "Opt-In Versus Opt-Out":** Many governments have  
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42  
43 moved to an 'opt-out' default (i.e., presumed consent to organ donation, unless an  
44  
45  
46 individual actively opts out) from an 'opt-in default' (i.e., the default is to be a non-  
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48  
49 donor unless one actively registers). Some countries (e.g., Austria) have a "hard-opt-  
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51  
52  
53 out system" where the registration will be followed, regardless of the families' wishes,  
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56  
57 whereas other countries (e.g., Spain) offer a "soft opt-out" system whereby families  
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4 of potential donors are given the chance to refuse (Reinders, van Kooten, Rabelink,  
5  
6  
7 & de Fijter, 2018).

10  
11 It has been shown that, on average, changing the default to an opt-out system  
12  
13  
14 leads to an increase in donation rates (Bilgel, 2012; Johnson & Goldstein, 2003;  
15  
16  
17  
18 Rithalia, Myers & Snowden, 2009; Ugur, 2015) and this change is supported by  
19  
20  
21  
22 public opinion (Moseley & Stoker, 2015; Rockloff & Hanley, 2014; van Dalen &  
23  
24  
25  
26 Henkens, 2014). However, while, on average, opt-out is associated with higher  
27  
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29  
30 deceased donations, compared to opt-in, it is also associated with lower living  
31  
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33  
34 donations (Shepherd, O'Carroll & Ferguson, 2014). Indeed, there are a number of  
35  
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37  
38 other concerns about moving to an opt-out default that detract from its actualized  
39  
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41  
42 effectiveness (see McCartney, 2017; Wellesley, 2011; Willis & Quigley, 2014). The  
43  
44  
45  
46 main concerns (Table 3) with an opt-out system include: (1) an epidemiological focus  
47  
48  
49  
50 on the average that obscures important cross-country variance, with many opt-out  
51  
52  
53  
54 countries performing less well than opt-in countries, (2) reduced living donation  
55  
56  
57  
58 rates, (3) difficulty interpreting what passively not opting-out means in terms of the  
59  
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61  
62 donor's true preference to be a donor, (4) moral objections relating to 'state'

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4 ownership of organs and lack of autonomy, (5) potential negative consequences of  
5  
6  
7 the 'lone wolf effect' whereby people are more likely to follow the lead of others de-  
8  
9  
10 registering, as signalled by posts on social media for example, and opt-out and (6)  
11  
12  
13 inability to establish causality. Furthermore, while the Spanish system is widely  
14  
15  
16 heralded as a great illustration of the success of an opt-out system, having now  
17  
18  
19 achieved 40 deceased donors per million (Matesanz, Gil, Coll, Mahillo & Marazuela,  
20  
21  
22 2017), Spain does **not** have an opt-out register for those who do not wish to become  
23  
24  
25 organ donors. The presumed consent law in Spain is thus dormant. In these  
26  
27  
28 circumstances, Spain's world-leading deceased organ donor rate cannot be  
29  
30  
31 attributed an opt-out system (Fabre, Murphy & Matesanz, 2010). Instead, the  
32  
33  
34 pioneers of the "Spanish model" attribute its success to three main features: (1)  
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36  
37 promoting early referral of donors from outside intensive care unit and incorporating  
38  
39  
40 the option of organ donation into end-of-life care, (2) expanding the criteria for organ  
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42  
43 use (e.g., from older donors), and (3) developing donation after circulatory death  
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53 (Matesanz et al. 2017).  
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4 Many countries have implemented a soft opt-out system where removal of  
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7 organs goes ahead only with family agreement. Indeed, under an opt-in system, the  
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10 UK has one of the highest family refusal rates for organ donation in the world, with  
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12  
13 34% of families currently refusing. This will possibly be higher under an opt-out  
14  
15  
16 system where it may be impossible for relatives to infer the true preference of the  
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18  
19 potential donor. While Vincent and Logan (2012) suggested a set of potentially  
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21  
22 modifiable factors relating to the family approach, the uncertainty that deemed  
23  
24  
25 consent brings is hard to overcome. Importantly, family members often later regret  
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27  
28 not giving consent (see Burroughs, Hong, Kappel & Freedman, 1998; Rodrigue,  
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Cornell & Howard, 2008).

**Increasing Registrations Within an Opt-in System:** If an opt-out system does  
not solve the organ shortage problem, it could be argued that the focus should be to  
improve registration and donation rates under an opt-in system. Since 2009 under  
the UK opt-in system, there has been a steady annual increase in the number of  
registered donors, increasing from 16.1 million in 2009 to 24.9 million in 2018  
(NHSBT, 2017-2018).

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4 One option to further enhance this growth is by using *social media* (e.g.,  
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7 WhatsApp, Facebook, Twitter). Social media, as well as web-based and print media  
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10  
11 opinion and comment, play an important role in organ donor recruitment that can be  
12  
13  
14 capitalized on (Aykas, Uslu & Simsek, 2015; Bail, 2016; Bramstedt & Cameron,  
15  
16  
17 2017; Brzezinski & Klikowicz, 2015; Cameron et al., 2013). A good example of this is  
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21 a *Facebook* campaign that gave individuals the opportunity to post status updates  
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23  
24 with respect to their organ donor registration which resulted in increased  
25  
26  
27  
28 registrations (Cameron et al., 2013). Thus, rather than an expensive change to an  
29  
30  
31 opt-out system, resources are perhaps better spend enhancing the opt-in system  
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33  
34 with social media used to increase registrations under an opt-in system.  
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39 *Reciprocal altruism* is another potential effective mechanism to increase  
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41  
42 organ donor registration under an opt-in system (Landry, 2006). Reciprocal altruism  
43  
44  
45 (direct and indirect) has a selfish component (Ma et al., 2017; Nowak, 2006), thus  
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48  
49 Landry proposed that campaigns should appeal to individuals' self-interest but  
50  
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52  
53 balance this against their desire to do what is fair and just. He termed this voluntary  
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56 reciprocal altruism (VRA). This is achieved by asking people to consider if they  
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4 would 'accept' an organ if they needed one, highlighting self-interest ('you may need  
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6  
7 an organ') and reciprocity and fairness ('if we do not register to give there may not be  
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9  
10 a sufficient supply for us all'). These ideas gained some support in a pilot study  
11  
12  
13  
14 which showed that medical students' intentions to donate were higher following  
15  
16  
17 exposure to a VRA message (Landry, 2006). Developing on this, O'Carroll, Haddow,  
18  
19  
20 Foley, and Quigley (2017) and O'Carroll, Quigley and Miller (2018) showed that non-  
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22  
23 registered participants exposed to a VRA message, compared to controls, reported  
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25  
26 greater intentions to register. The effect of VRA on behaviour (donor registration)  
27  
28  
29 was demonstrated by the results from a large scale (1 million participants) trial  
30  
31  
32 comparing nine different messages on UK driving license application web pages. A  
33  
34  
35 VRA message ("If you needed an organ transplant, would you have one? If so,  
36  
37  
38 please help others") was the most successful, followed by a loss framed message  
39  
40  
41 ("Three people die every day because there are not enough organs") (Sallis et al., 2018).  
42  
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44  
45 Norm based strategies ("Every day thousands of people who see this page decide to  
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48 register") were the least successful, and when combined with an image of people,  
49  
50  
51 norm-based strategies had a detrimental effect, resulting in a reduction in donor  
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60 registrations (Sallis et al., 2018). The UK NHSBT advertising campaign currently



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3  
4 uses VRA, asking “If you needed an organ transplant would you have one?”(NHSBT,  
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6  
7 2016).

11 *Anticipated regret* (AR) is an example of an anticipated affective reaction.

14 Asking people to anticipate possible future regret is a potentially powerful behaviour  
15  
16  
17  
18 change technique (Brewer, DeFrank & Gilkey, 2016). O’Carroll, Dryden, et al. (2011)  
19  
20  
21 and O’Carroll, Foster, et al. (2011) assessed the impact of a simple AR intervention,  
22  
23  
24  
25 showing that intention to join the UK ODR was significantly higher for participants  
26  
27  
28 asked to rate possible AR compared with a control condition. However, a  
29  
30  
31  
32 subsequent large-scale trial with 14,509 members of the Scottish public which  
33  
34  
35 measured actual registrations, found significantly *lower* registrations in the AR arm  
36  
37  
38 compared to a pure control (O’Carroll, Shepherd, Hayes, & Ferguson, 2016). In  
39  
40  
41  
42 attempting to understand why the brief AR intervention led to a significant decrease  
43  
44  
45 in registrations, the authors speculated that as those in the active arms completed  
46  
47  
48 items assessing affective responses in relation to organ donation (e.g., jinx) and  
49  
50  
51 control participants did not, they were ‘primed’ to consider negative beliefs about  
52  
53  
54 organ donation. To test this possibility, Doherty, Dolan, Flynn, O’Carroll, and Doyle  
55  
56  
57 (2017) found that omitting negative affective items resulted in higher intention to  
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4 donate organs and marginally higher rates of acceptance of organ donor cards  
5  
6  
7 (proxy measure of behaviour). These findings suggest that questions about negative  
8  
9  
10 affective responses require careful consideration and should probably be omitted in  
11  
12  
13  
14 public health campaigns attempting to increase organ donor registration (Doherty et  
15  
16  
17  
18 al., 2017).

21 **Community Based Interventions:** Golding and Cropley (2017) conducted a  
22  
23  
24 narrative systematic review of psychological interventions designed to increase the  
25  
26  
27  
28 number of individuals in the community who register as organ donors. They identified  
29  
30  
31  
32 24 studies, 19 of which found a positive intervention effect, but only 8 were rated as  
33  
34  
35 being methodologically robust. The previously cited study by Alvaro et al. (2011),  
36  
37  
38 which provided an immediate registration opportunity (ICRO), was found to be the  
39  
40  
41  
42 most effective with an OR of 5.9.

45 **Primary Care Interventions:** Pedder-Jones, Papadopoulos and Randhawa  
46  
47  
48 (2017) showed that successful interventions in primary care were characterised by  
49  
50  
51  
52 active participant engagement and those that encouraged donation at the point of  
53  
54  
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56 patient contact (ICRO).  
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4 **“Myth-Busting”**: Myths or incorrect beliefs (e.g., “Doctors may not try their best  
5  
6  
7 to save my life if I am registered as an organ donor”) are common deterrents of  
8  
9  
10 organ donation registration. Miller, Currie and O’Carroll (2018) recently evaluated the  
11  
12 effectiveness of myth correcting interventions. They found that for participants who  
13  
14 plan to opt-in to the organ donor register or passively register (deemed consent),  
15  
16  
17  
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20  
21  
22 dispelling myths acted to increase donor intentions. However, for the group the  
23  
24  
25 intervention is aimed at (i.e., those who plan to opt-out or are unsure), dispelling  
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32 **Xenotransplantation**: A very different intervention to reduce the organ  
33  
34  
35 shortage is to move to a source of organs other than humans: *Xenotransplantation*  
36  
37  
38 (Denner, 2014). Recent advances in engineering pig (the most suitable organism for  
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The potential endless supply of organs offers a real solution to the organ shortage

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4 (Harris et al., 2014; Hryhorowicz, Zeyland, Slomski, & Lipinski, 2017). However,  
5  
6  
7 there is an urgent need to assess acceptability to patients and relatives.  
8  
9

10  
11 **Correlated Behaviours:** Blood and organ donation behaviours are consistently  
12  
13  
14 correlated across countries (Ferguson et al., in press). This implies that recruiting  
15  
16  
17 organ donors from blood donors, or vice-versa, is a distinct possibility. Indeed, in  
18  
19  
20 some countries (e.g., Australia) blood donors are encouraged to become organ  
21  
22  
23 donors (<https://www.donateblood.com.au/learn/organ-tissue-donation>).  
24  
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### 29 **Common Themes**

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33 While blood and organ donation are both health-based voluntary philanthropic  
34  
35  
36 acts, they are different in a number of ways (Table 1), have different predictors, and  
37  
38  
39 require unique interventions. There are, however, a number of communalities that  
40  
41  
42  
43 can be identified across the two that suggest common themes.  
44  
45  
46

47 **Emotions and Empathy Gaps.** A key emerging theme from the review on blood and  
48  
49  
50 organ donation is the role of emotional experiences. Such processes tend to be  
51  
52  
53  
54 dynamic – blood donors cycle through a number of donations, and people consider  
55  
56  
57 registering as an organ donor and then register or not. Thus, we need to consider  
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4 this dynamic emotional journey and *empathy gaps* offer one theoretical tool to do  
5  
6  
7 this. An *empathy gap* emerges when people have difficulty in predicting how they will  
8  
9  
10 act in an emotional state different to their current one (Loewenstein, 2000). Important  
11  
12  
13 to this discussion are *prospective hot-cold* and *cold-hot* empathy gaps. Prospective  
14  
15  
16 gaps refer to how well people predict their future behaviour, when in a different  
17  
18  
19 emotional state to their current one. Hot-cold gaps are experienced when people in  
20  
21  
22 an aroused emotional state underestimate how their current emotions influence their  
23  
24  
25 decisions. In cold-hot gaps, people in a cold emotional state under-estimate how their  
26  
27  
28 emotions in an aroused state will influence their behaviour. There are *cold-hot*  
29  
30  
31 *prospective* empathy gaps in both blood and organ donation behaviour. For blood  
32  
33  
34 donation this focuses on people's prospective prediction that they may faint when  
35  
36  
37 donating blood. Indeed, the potential blood donor's emotional responses are very  
38  
39  
40 different depending on whether or not they can observe images and equipment  
41  
42  
43 associated with blood donation (Clowes & Masser, 2012; Masser, France, Himawan,  
44  
45  
46 Hyde, & Smith, in press), with anxiety being higher when blood donation  
47  
48  
49 paraphernalia are present. Similarly, *cold-hot prospective* empathy gaps are likely to  
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51  
52 be present in relation to deceased organ donation registration. That is, while people  
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4 express a positive attitude towards organ donation (70% or more) in the UK, only  
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6  
7 approximately 38% register. Reflecting a possible cold-hot prospective empathy gap,  
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9  
10  
11 people may feel more negative emotions when it comes to signing up on the organ  
12  
13  
14 donor register than they anticipated, and this is sufficient to prevent them from  
15  
16  
17  
18 registering.  
19  
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22  
23         There are also *hot-cold retrospective empathy-gaps* in both blood and deceased  
24  
25 organ donation. The blood donor in the hot after-glow of donation, may over estimate  
26  
27 their likelihood of return, but as they emotionally cool-off they may recall the donation  
28  
29 less positively. Thus, interventions to enhance blood donors' recall of post-donation  
30  
31  
32  
33 positive affect would be a useful avenue to pursue. Ferguson and Masser (2018)  
34  
35  
36  
37 provide a detailed theoretical account of the application of empathy gaps to blood  
38  
39  
40 donor research. Applying *hot-cold retrospective empathy-gaps* may also explain why  
41  
42  
43  
44 many family members express regret for earlier decisions not to consent to organ  
45  
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47  
48 donation from their relatives (Rodrigue et al. 2008), as their decision was made in a  
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51 hot emotional state and later reflected on in a cold emotional state.  
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4 mechanisms to boost organ donor registrations under an opt-in default may be more  
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6  
7 successful, especially if combined with a VRA manipulation or social media updates.  
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**Table 1.** Behavioural characteristics of Blood and Organ Donation

	Whole Blood Donation	Organ Donation		
		Posthumou s	Living- familial (directed)	Living – stranger (non- directive/altruistic)
Voluntary	√	√	√	√
Anonymous	√	√		√
Single Act	√	√	√	√
Repeat Act	√	√		√
Costly: Self	√		√	√
Costless: Self		√		
Benefit: Stranger	√	√		√
Benefit: Relative			√	
Genetic Similarity	√	√	√	√
Phenotypic Similarity		√	√	√
Feedback	√		√	
Free-riding	√	√		
Obligation felt by recipient			√	
Surrogate Decisions		√		

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**Table 2.** Links Between Volunteer Function, Self-Determination Theory-motivations and Mechanisms of Altruism (see also Ferguson & Lawrence 2015)

Volunteer Functions	Definition	Self-Determination Theory (SDT) Motivations	Link to MOA
<i>Values</i>	Volunteers can express values of altruism/humanitarianism	Extrinsic: Identified regulation	Pure Altruism
<i>Understanding</i>	Volunteer can learn new skills that they would not normally have the chance to exercise		Self-Interest
<i>Social</i>	Volunteer in activities that important others view favourably and strengthen social bonds		Reputation Building & Gratitude
<i>Career</i>	Volunteering enhances career related goals	Extrinsic: external regulation	Self-Interest
<i>Protective</i>	Volunteering is ego protecting by reducing feelings of guilt from being better off	Extrinsic: Introjected regulation	Inequality Aversion
<i>Enhancement</i>	Volunteers grow personally and emotionally	Intrinsic regulation	Warm-Glow

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**Table 3. Advantages and Disadvantages of an opt-out deceased organ donor registration system.**

	<i>Evidence</i>	<i>Reference</i>
<b>Advantages</b>		
Under opt-out more organs for transplantation are available	Epidemiological evidence that countries with opt-out defaults, on average, to have higher transplantation rates than opt-in countries	Bilgel, 2012; Johnson & Goldstein, 2003; Rithalia, Myers & Snowden, 2009; Ugur, 2015; Shepherd, O’Carroll & Ferguson, 2014
Power of defaults	The default option is on average selected by the majority	Thaler & Sunstein, 2009
Positive public attitude	Members of the general public are positively disposed to an opt-out system	
<b>Disadvantages</b>		
High donation variance: The range of donation/transplantation rate varies widely by opt-out and opt-in countries	For example, Sweden, Luxembourg and Bulgaria have opt-out default since 1996 yet remain lowly-ranked countries for organ donation within Europe, and lower than many opt-in countries such as England	Shepherd, O’Carroll & Ferguson, 2014
Negative impact on living donations	Under opt-out default the number of living donations goes down. This is especially the case for non-directed living donations	Fernandez, Howard & Krose, 2013; Shepherd, O’Carroll & Ferguson, 2014
Individual presumed content is not interpretable	<i>Passively</i> not opting-out (deemed consent) does not provide any information about a person’s true preferences to be a posthumous organ donor. People may not opt-out because; they want to be a donor, they forgot to, inertia, or lack of effort. Thus, there may be people who do not want to be a donor who are on the register by ‘default’. This lack of certainty is problematic	Beshears, Choi, Laibson & Madrian, 2008

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4 when it comes to asking for relatives' consent and this group will  
5 reflect a large percentage of donors registered under an opt-out  
6 system  
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8 Moral concerns

9 There are public concerns around medical mistrust and  
10 reactance to State "ownership" of organs and lack of personal  
11 autonomy  
12

Csillag, 1998 ; MacKay & Robinson, 2016

13 'Lone wolf effects' – a reciprocal  
14 effect where by people follow the  
15 lead of a person opting-out and  
16 follow suit and this is a stronger  
17 effect than following the lead of  
18 someone opting in ('A good  
19 Shepherd Effect')

20 In the world of social media there is evidence that updating  
21 Facebook status about being an organ donor greatly enhances  
22 registration under an opt-in system. Game theoretic analyses  
23 and data shows that an opposite and more powerful 'lone wolf  
24 effect' emerges under opt-out. Here when people share  
25 information that they have decided to opt-out, it acts as a strong  
26 social force resulting in others rapidly following suit

Ferguson, Shichman & Tan, 2018

27 Causal Status

28 The cross-sectional nature of the epidemiological evidence  
29 means that it is not possible to infer any real causal role to a  
30 change to opt-out. While Shepherd et al. (2014) used  
31 instrumental variable to infer a causal role of an opt-out system,  
32 this does not allow for an estimate the direct causal role the  
33 dynamic change from opt-in to opt-out and visa-versa.

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