The psychological evaluation of Samaritan kidney donors: a systematic review

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Background. Living kidney donation to a loved one has become common practice. Another type of living donation that is becoming more acceptable to the transplant community is ‘Samaritan donation’. Samaritan kidney donors are willing to donate to patients they do not know. Until recently there has been great reluctance to accept the offers of Samaritan donors because it was feared that these donors might be mentally unstable.

Method. The purpose of this article is to review the literature about the psychological evaluation of potential Samaritan kidney donors for donor suitability. We have performed a systematic literature search in PubMed, ISI Web of Science and PsycINFO. We compare and discuss how each study approaches the question about Samaritan donor selection. In addition, we have also screened the studies for reports of rejections of Samaritan donors on psychological grounds.

Results. We have found five articles that at least in some detail describe the evaluation of potential Samaritan donors. For all five articles found, a consultation with either a psychiatrist or a psychologist formed a standard part of the donor evaluation procedure. This evaluation consisted of an interview, and in most instances, additional psychometric testing. According to the articles found, the two major criteria for donor rejection were psychopathology/psychological instability and motivational issues. Three studies reported on the rejection of potential donors on psychological grounds.

Conclusions. The evaluation of Samaritan kidney donors is a developing field in clinical medicine. Given the relatively low incidence of these types of donations, we recommend the exchange of experience between centres that run a Samaritan donor programme, in order to improve donor evaluation criteria.

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Introduction

Living kidney donation to a family member or a partner has become common practice. However, the idea of donating one of your kidneys to a patient on the waiting list for transplantation and who you don’t know, is one step further. A thirty-year-old man decided to do so: ‘It is about the feeling you get if you are able to do something for someone else in a meaningful way.’

(Daily newspaper: De Limburger, Wednesday, 16 November 2005).

An important clinical question is the validity of such motivation: is the motivation a well thought out aspiration, or is it a sign of mental instability? A careful psychological evaluation to distinguish between the two is necessary if society wishes to proceed with ‘Samaritan donation’. This article describes a review of the literature on how such evaluation can best be performed.

The shortage of kidneys for transplantation is widely considered to be a problem for patients with end-stage renal disease. In The Netherlands, the waiting list for deceased donor kidney transplantation has increased. Average waiting times nowadays range from 2 years for patients with blood type AB to 5 years for patients with blood type O (Dutch Transplant Foundation, 2006). In the meantime patients are dependent on dialysis treatment, which is associated with severely lowered quality of life, morbidity and mortality (Lumsdaine et al. 2005); approximately 25% of all Dutch patients die while waiting for a transplant (Renine Foundation, 2006).

Living kidney donation has alleviated the long waiting time. In the past, only the patients’ close relatives were considered as living donors. However, as non-related living donors’ kidneys proved to have similar good outcomes, the proportion of non-related donors such as spouses and friends has increased significantly over the past years (Terasaki et al. 1995,
Recently, another type of living donation is becoming more acceptable to the transplant community – the ‘Samaritan donation’. Samaritan donors are people who are willing to donate to patients they do not know. The idea and use of Samaritan donors goes back as early as 1971, when Sadler et al. first described a sample of Samaritan donors. Despite this early report, up until recently there has been great reluctance to accept the offers of Samaritan donors. The most important reason for this reluctance is the possibility that these donors may not be mentally stable (Henderson et al. 2003). Although a case has been reported where the donor saw giving away all his body parts as an inevitable necessity (Truog, 2005), feelings and fears of donor instability often proved not to be true (Sadler et al. 1971; Landolt et al. 2003; Jacobs et al. 2004; Morrissey et al. 2005; Jendrisak et al. 2006).

Over the past few years, the reluctance towards Samaritan donors seems to be decreasing. Some transplant centres have started to publish their initial results on Samaritan donation, and other centres have started to develop protocols for their planned Samaritan donation programmes (Crowley-Matoka & Switzer, 2005). A recent survey has shown that, in the absence of a common ‘Samaritan donor protocol’, centres seem to be developing their own separate protocols (Crowley-Matoka & Switzer, 2005). Many local protocols appear to share the basic existing ‘regular’ living kidney donation protocols, giving special attention to the psychological and/or psychiatric evaluation of the Samaritan donor. At present, however, information is scarce about how this specific psychological/psychiatric evaluation can best be constructed. The purpose of this article was to systematically review the existing literature about the psychological/psychiatric evaluation of Samaritan donors. The rationale for a well-defined psychological tool to screen Samaritan donors is to rule out cases where the psychological risks of donation are larger than the benefits. This is especially important because psychological benefits are generally seen as a major moral justification for the surgical practice of living donor nephrectomies (Abecassis et al. 2000).

Method

As ‘Samaritan donation’ is a specific form or subcategory of ‘living kidney donation’, we first studied the commonly-used current guidelines and consensus reports for the psychological evaluation of directed living kidney donors (such as parents or spouses). By including these guidelines, we can examine to what extent protocols for the psychological evaluation of Samaritan donation can or should differ from the psychological evaluation of the more traditional living kidney donors. In April 2007, we performed a systematic literature search in Pubmed, ISI Web of Science and PsycINFO. We used the search terms: ‘Samaritan’ OR ‘anonymous’ OR ‘nondirected’ OR ‘non-directed’ OR ‘altruistic’ AND ‘kidney donation’. We did not make time restrictions with respect to publication dates. We screened all articles found for a detailed description of the contents of the psychological/psychiatric evaluation of Samaritan kidney donors and checked whether psychological exclusion criteria for donation were reported. We also screened the studies found for reports of rejections of Samaritan donors on psychological grounds. Where articles referred to articles on Samaritan donation that we had missed as a result of our initial choice of search terms, we included these articles as well (i.e. the snowball method). In all articles, we studied how each clinical group in practice approaches the question about eliminating psychopathology or eliminating patients with poor motivation.

Results

Guidelines and consensus reports for psychological evaluation for ‘conventional’ living kidney donation

Before presenting the results for the Samaritan kidney donor evaluation, we first present the results for conventional living kidney donation. The best descriptions or guidelines for the psychological evaluation of ‘conventional’ living kidney donation were found in three types of documents: (1) consensus statements, (2) guidelines and (3) scientific reports. For each type, we included two documents: the consensus statement on the live organ donor and the Amsterdam Forum reports (Abecassis et al. 2000; Ethics Committee of the Transplantation Society, 2004; Delmonico et al. 2005); the current US and UK guidelines (Kasiske et al. 1996; British Transplantation Society and the Renal Association, 2005); and the studies of Olbrisch et al. (2001) and Leo et al. (2003). There was considerable agreement about the headings of the contents of such an evaluation. We identified five common elements: (1) the purpose of the evaluation is to uncover clinical psychiatric disorders that would preclude donation, (2) the assessment of psychosocial stability, (3) to assess whether the donor comprehends all risks and benefits involved, and is capable of making an informed decision. Both the morbidity/mortality risks for the donor and the likelihood of success for the recipient should be discussed; (4) the absence of pressure or coercion to donate and, in most instances; (5) the donor’s relationship with the recipient and within the context of the wider family. Some documents explicitly included the motivation to donate as a topic for
the evaluation (Olbrisch et al. 2001; Leo et al. 2003), whereas for others, motivational issues fell under the exploration of the voluntary nature of the decision. There were differences between the documents with respect to the inclusion of third parties in the evaluation procedure. Two documents mentioned the inclusion of third parties: Olbrisch et al. (2001) included a collateral spousal interview in their evaluation procedure, and Abecassis et al. (2000) reported that for potential donors undergoing mental health treatment, the mental health professional caring for this patient should contribute to the evaluative process. Another difference between the documents concerns informing the potential donor of the psychological risks and benefits associated with kidney donation. Although all documents state that a well-informed decision should be made (thereby implicitly including the psychological risks and benefits of a donation procedure), Kasiske et al. (1996) are the only researchers who explicitly describe these psychological risks: ‘A small minority of patients may, at some time, become depressed as a result of kidney donation’, ‘rare cases in which the donor committed suicide after the kidney they had donated failed’ and possible adverse effects on marriage. Benefits, which are much more common, include superior psychological health compared to the rest of the population, increase in self-esteem, and improvement of the relationship with the donor (Kasiske et al. 1996). Furthermore, there exists considerable difference between the extent to which the different documents describe the kind of psychopathology that could be a contra-indication for living kidney donation. In this respect, the study of Leo et al. (2003) provides the most concrete descriptions. This study includes a table of poor prognostic factors that may be identified in presurgical psychological evaluation of prospective living kidney donors. These factors are: psychotic disorders, major mood disorders, major depression, bipolar disorder, substance abuse/dependence, severe personality disorders, risks for suicide, issues influencing the decision to donate (coercion, monetary gain, economic factors, desire to enlist the organ recipient in a reciprocal relationship, desire to create indebtedness in the organ recipient). The study of Olbrisch et al. (2001) does not proceed from diagnoses, but rather from questions such as ‘Is the donor sufficiently emotionally stable to cope with stresses which may come up before, during and after the donation? Is there overt or indirect evidence that the wish to be a donor reflects self-destructive or suicidal feelings? What is the potential that the donor will develop somatization symptoms that could result in high medical resource utilization, prolonged disability, chronic pain, attention seeking, or other secondary gain as a result of undergoing an elective surgery? Is the donor prepared to handle medical complications that either the donor or the recipient might experience?’ Despite the differences, what is commonly described in these documents is that decisions on rejecting or accepting living kidney donors on psychological grounds should be made on a case-by-case basis, and that there is not a ‘diagnosis-based recipe’ for these decisions.

**Literature review: psychological evaluation for Samaritan kidney donation**

Using our search terms, we found 84 articles on Samaritan donation by using Pubmed, 75 in ISI Web of Science and three in PsycINFO. After controlling for overlap between the results found, 111 articles remained. Only five of these included detailed descriptions of the contents of the psychological/psychiatric evaluation of the donors (Jacobs et al. 2004; Gilbert et al. 2005; Morrissey et al. 2005; Jendrisak et al. 2006; Dew et al. 2007). Typically, this evaluation starts as soon as the interested potential Samaritan donor telephones the transplant centre. During this telephone conversation, the transplant coordinator or transplant nurse performs an initial evaluation to rule out those people with obvious medical or psychosocial contra-indications. Following this evaluation, if candidates are deemed eligible for donation, they receive an information pack of donor educational information. Next, if after reading the information the donor candidate is still interested in donation, he or she has to contact the transplant centre again to make arrangements for further donor evaluation. For all five articles found, a consultation with either a psychiatrist (Gilbert et al. 2005; Morrissey et al. 2005) or a psychologist (Jacobs et al. 2004; Jendrisak et al. 2006) is a standard part of the donor evaluation procedure. This evaluation consists of an interview and, in most instances, additional psychometric testing. The interview consists of a variety of topics. The articles found differ in regard to the extent they describe the topics of the interview. The shortest description of interview topics is provided by Jendrisak et al. (2006): ‘a standard psychiatric interview using DSM-IV criteria for major psychiatric disorders such as depression, anxiety, mania, schizophrenia, substance abuse, and other disorders along with a MMSE. Donor motivation is also addressed in-depth during the interview.’ Gilbert et al. (2005) also provide a compact description of the interview contents: ‘motivation, decision-making process, health concerns during and after donation, expectations of the relationship with the recipient, family members’ viewpoint on the donation and health expectations for the recipient. An Axis I, II
or III impression is given and also a recommendation about whether or not to proceed with the donation.’ Jacobs et al. (2004) and Dew et al. (2007) provide the most detailed description of the topics assessed during the interview. In addition to the interview topics already named above, they include: ‘history and current status’ (Dew et al. 2007), employment, cultural background, religious beliefs and practices, history of volunteering and charitable deeds, and also information about the financial situation of the donor in their evaluation interview (Jacobs et al. 2004; Dew et al. 2007). Morrissey et al. (2005) refer to Jacobs et al. (2004) in their description of interview contents. Only Jendrisak et al. (2006) suggest using a standard DSM-IV interview for the evaluation of psychiatric disorders. Gilbert et al. (2005) state that an Axis I, II or III impression is given, but do not say how this was accomplished. Along with the interview, psychometric testing forms an important part of the psychological evaluation of Samaritan donors. Both Jacobs et al. (2004) and Jendrisak et al. (2006) make use of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher et al. 1989). In addition, Jendrisak et al. (2006) apply the Temperament and Character Inventory (TCI) and the Mini-Mental State Examination (MMSE). Gilbert et al. (2005) state that the psychiatrist used standard psychiatric tools to assess the competence of the donor in making an informed judgment, the presence of social or medical concerns that would place an undue burden on the individual or their family during the post-donation period, and the presence of psychiatric illness. However, the nature of these ‘psychiatric tools’ is not described. In the study of Morrissey et al. (2005), the use of psychometric testing is not mentioned. Four out of the five studies recommend that a family member of the potential donor should take part in the evaluation procedure (Jacobs et al. 2004; Gilbert et al. 2005; Jendrisak et al. 2006; Dew et al. 2007).

The five articles vary in their description of contra-indications or exclusion criteria for Samaritan donation (summarized in Table 1), except for Morrissey et al. (2005), who follow Jacobs et al. (2004) in their description of contra-indication on psychological

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<th>Article</th>
<th>Contra-indications</th>
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<td>Adams et al. (2002)</td>
<td>(1) An unrealistic expectation or demand that the transplant will be free from rejection and failure; (2) the misperception by the donor that if the transplant is not successful, it is because of personal failure as a donor; (3) monetary compensation; (4) a desire for media attention (that could not be supported by the transplant centre); (5) a response or remedy for a psychological malady, such as severe depression, low self-esteem, or other underlying mental illness; (6) a desired selection of the recipient by gender, race or ethnicity; (7) a desired involvement in the recipient’s life after donation, possibly unwanted by the recipient, that could not be supported by the transplant centre</td>
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<td>Jacobs et al. (2004)</td>
<td>(1) An impulsive decision-making process; (2) unrealistic or ulterior motives to donate (e.g. individual or societal approval, compensation, atonement, redemption, media attention); (3) severe forms of depression, active grief, low self-esteem, or other underlying or untreated mental illness. Candidates are ruled out if psychosocial issues are present that could increase their vulnerability to withstand potential donor-related stresses or that could exacerbate any psychological morbidity; (4) under 21 years of age</td>
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<td>Gilbert et al. (2005)</td>
<td>‘Evidence of significant psychiatric illness’: in that case ‘offers are rejected as lacking the mental health necessary for an authentically voluntary offer’</td>
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<td>Dew et al. (2007)</td>
<td>Risk factors for poor psychosocial outcomes in living kidney donors are described; factors of heightened importance of unrelated donors (such as Samaritan donors) are in italics. They also describe a number of protective factors: significant past or ongoing psychiatric symptoms or disorders; substance abuse or dependence; limited financial capacity to manage donation (lost wages, travel, job concerns); lack of health insurance; limited capacity to understand donor risks/recipient benefits and alternatives; increased medical risks (e.g. chronic pain conditions); marked ambivalence about donating, or unrealistic expectations about the donation experience and potential recipient outcomes; motives reflecting desire for recognition, or a desire to use the donation to develop personal relationships (e.g. desire for publicity, desire for a relationship with an individual or with treatment providers); multiple family stressors/obligations/concerns; subordinate relationship (e.g. employee/employer) or other evidence of coercion; evidence of, or expectation of, secondary gain (e.g. avoidance of military duty, financial support from recipient); poor relationship with family; poor family support for donation</td>
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grounds (although they do not mention the age restriction), and Jendrisak et al. (2006) do not explicitly describe contra-indications for Samaritan donation. In addition to these five articles, our literature review found a paper by Adams et al. (2002), stating that contra-indications to Samaritan donation are the same as for directed donation. They list a number of reasons for donor exclusion, which are also summarized in Table 1. Given these contra-indications, we studied how many Samaritan donor candidates were reported to have been rejected for donation on psychological/psychiatric grounds so far. Our literature survey yielded five reports on the outcomes of Samaritan kidney donation programmes. These results are summarized in Table 2, which also includes the results for those donors who were receiving counselling or psychotropic medication, but nevertheless were accepted for donation. There were no adverse psychological consequences after donation reported for these donors.

In addition to the studies described above, we found three more studies that did not describe the clinical evaluation procedure of Samaritan donor candidates in particular, but rather could be described as research into the personality characteristics of (possible) Samaritan donors (Henderson et al. 2003; Landolt et al. 2003; Boulware et al. 2005). Landolt et al. (2003) found that people likely to volunteer as Samaritan donors were more likely to ascribe humanitarian reasons for their action and less likely to be influenced by the external costs of donation. Their Samaritan donor candidates completed the Revised NEO Personality Inventory (NEO PI-R), a self-report instrument measuring five major personality domains (Costa & McCrae, 1992; Costa & Widiger, 1994). The results showed that they were more likely to score highly on the NEO PI-R subscales ‘openness to experience’, indicating a certain willingness to question authority and to entertain new ethical, social and political ideas. They were also more likely to score highly on ‘agreeableness’, indicating qualities such as kind-heartedness, friendliness, benevolence, empathy and a belief in the fundamental goodness of others (Landolt et al. 2003). The study of Jendrisak et al. (2006) also included a validated questionnaire on personality traits, namely the TCI (Cloninger et al. 1994). They found that Samaritan donors were not thrill seekers, and were less harm-avoidant than the general population. They scored lower on self-transcendence than the general population, suggesting that as a group they were not especially tied to organized religion or spirituality. Boulware et al. (2005) found that potential stranger donors were willing to undergo greater risks associated with donation (compared to the general population), but that there were no differences with respect to prevalence of depression and anxiety symptoms, and no differences with respect to altruistic or religious attitudes. Regarding religious motives, the results of the various studies are not in agreement. Contrary to the studies of Jendrisak et al. (2006) and Boulware et al. (2005), Henderson et al. (2003) suggest that people likely to volunteer as Samaritan donors are more likely to have a spiritual belief system. The study of Jacobs et al. (2004) provides evidence that at least some of the Samaritan donors are motivated by religion, as nearly a third of the 49 candidates assessed in their study had strong religious and/or Christian convictions and believed that donating was an act of living out their faith and their dedication to serving others.

Table 2. Donor exclusion on psychological grounds

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<th>Article</th>
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<td>Jacobs et al. (2004)</td>
<td>Five had received counselling at some point in their lifetime, five were taking psychotropic medication, and three were in active therapy for some type of intervention</td>
<td>Four out of 51 had been rejected for ‘psychosocial reasons’, but these reasons were not further specified</td>
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<td>Gilbert et al. (2005)</td>
<td>Four donors were taking medication for depression</td>
<td>Thirteen out of 51: seven for active substance abuse, three for depression, and three for bipolar disorder</td>
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<td>Morrissey et al. (2005)</td>
<td>Two individuals had remote episodes of anxiety/panic disorder and depression and one had dysthemia, treated in the past for a 3-month period with antidepressants</td>
<td>None (0/16)</td>
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<tr>
<td>Jendriskak et al. (2006)</td>
<td>None (0/19)</td>
<td>Nine out of 76: anxiety, schizophrenia, body issues, pain history and fear</td>
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<td>Mark et al. (2006)</td>
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Discussion

The evaluation of Samaritan donors should at a minimum include the same issues as the evaluation of conventional living donors (Adams et al. 2002; Dew et al. 2007). In addition, a consultation with a psychologist or psychiatrist is a standard procedure in many transplant centres. Compared to the procedures for conventional living kidney donors, we found that motivational issues played a more prominent role in the evaluation of Samaritan donors. In conventional donation, the donor motivation is evaluated more in terms of absence of pressure (and good reasons for donation are more or less taken for granted), whereas the evaluation of the motivation of Samaritan donors is more extensive. Thus, in the case of Samaritan donation, the psychologist/psychiatrist is called in to evaluate psychopathology, the motivation for donation, and the possible relationship between psychopathology and motivation. As reported in the results section, we found no uniform description of what type(s) of psychopathology should preclude either a conventional living kidney donation or a Samaritan donation. Possibly because of this lack of standardization, it was revealed that in one study three people were rejected on grounds of depression (Gilbert et al. 2005), whereas in another study four people with depression and on medication were accepted for donation (Morrissey et al. 2005). There we no psychological complaints reported for these four donors after donation (Morrissey et al. 2005). With respect to the methods used to uncover mental illness, one study showed that a standard DSM-IV interview for the evaluation of psychiatric disorders is used (Jendrisak et al. 2006), or that at least an Axis I, II or III impression was given by the psychiatrist (Gilbert et al. 2005). We would recommend a standardized interview (for example, the Mini-International Neuropsychiatric Interview; Sheehan et al. 1998), but we think that in clinical practice the experience and preference of the treating psychologist/psychiatrist will be decisive. In addition, psychometric testing is used for the evaluation of Samaritan donors. The MMPI-2 is part of the evaluation protocol in the studies of Jacobs et al. (2004) and Jendrisak et al. (2006) (see also Roman et al. 2006). An important reason for including this instrument is that it is difficult for the respondent to anticipate the ‘correct’ answers because it is almost impossible to know what the right or wrong answers are. We think such a feature is helpful because in some cases the Samaritan donor might try to conceal something he or she thinks would be a contra-indication for donation (Olbrisch et al. 2001). It is also known from other studies that the way in which people fill out questionnaires is influenced by the specific context and, consciously or unconsciously, may bias the results (Passchier et al. 1993). The TCI is also used in the psychological evaluation of Samaritan donors (Jendrisak et al. 2006). Although the TCI adds to the evaluation of Samaritan donors, we question whether it is necessary to include this instrument as a standard in the clinical psychological evaluation of Samaritan donors. This instrument may be better suited for research into personality or other characteristics of Samaritan donors. We found that for the psychometric instruments described earlier, cut-off scores were lacking. Although Jendrisak et al. (2006) reported that the scores of the evaluated donors were within normal ranges, we are not clear whether this implies that donors would have been rejected if scores were significantly lowered or elevated. This can be compared to the situation of conventional living kidney donation evaluations, where decisions are also made on a case-by-case basis. To cite Dew et al. (2007): ‘The safety and well-being of each donor will be maximized only by considering (a) the unique circumstances that led the individual to come forward for donation and (b) the unique set of psychosocial risk and protective factors that the individual brings’.

Contrary to the open descriptions of unacceptable psychopathology, rules or criteria for evaluating the motivation of Samaritan donors seem to be much stricter. Adams et al. (2002) name seven categories of ‘unacceptable donor expectancies’ (Table 1). We think that several of these ‘unacceptable expectancies’ also apply to conventional, directed donation, such as expecting ‘monetary compensation’. Unacceptable donor expectations that apply exclusively to Samaritan donation are: ‘a desire for media attention (that could not be supported by the transplant center)’, ‘a response or remedy for a psychological malady’ and ‘a desired selection of the recipient by gender, race or ethnicity’. With respect to the latter issue, a full discussion of this issue is beyond the scope of this manuscript. In this respect we refer to the study of Hilhorst (2005), which provides a detailed discussion of the pros and cons of Samaritan donors being able to direct their donation. Regarding media attention, this motivation is also defined as unacceptable by Jacobs et al. (2004) and Morrissey et al. (2005). They name as untolerable motivations: individual or societal approval, compensation, atonement and redemption. They explicitly state that in such instances the offer would be declined (Jacobs et al. 2004; Morrissey et al. 2005). We think that one of the most important ‘unacceptable expectancies’ that Adams et al. (2002) describe is a response to, or a motive stemming from, a psychological malady. In addition to the psychological maladies named above, the possibility of borderline personality disorder...
deserves careful attention (APA, 1994). Typical of persons suffering from borderline personality disorder is a very weak sense of self-existence and self-boundary, resulting in feelings of inner emptiness and difficulty in relating to other people. Patterns of self-mutilation and suicide are common in this group. Someone suffering from this condition might want, for example, to donate a kidney to fill this inner emptiness with meaningful behaviour, or to cross physical body borders as an extreme attempt to become connected to some other person. Other conditions that could possibly influence the motivation to donate a kidney are psychosomatic disorders, especially factitious disorder and body integration identity disorder (Vandereycken et al. 1994; Furth & Smith, 2000; Horn, 2004).

Finally, a comment on the inclusion of third parties in the psychological evaluation of Samaritan donors. Jacobs et al. (2004), Gilbert et al. (2005), Jendrisak et al. (2006) and Dew et al. (2007) are positive about including a spouse or significant other of the donor in the evaluation process. We are supportive of this idea, and we think that it should be up to the psychologist/psychiatrist to decide in each specific situation whether he/she thinks it is necessary to include ‘a significant other’ of the potential donor. Furthermore, although the articles described in the earlier section on psychological evaluation for Samaritan kidney donation do not mention this procedure, like Abecassis et al. (2000) we would encourage the psychologist/psychiatrist to contact the former/present mental health professionals of the Samaritan donor, if applicable. This information should be seen and considered in the broader context of the whole evaluation procedure.

Why do we subject potential Samaritan kidney donors to a stricter psychological evaluation procedure than conventional living kidney donors? The underlying reason could be that we have insufficient data available yet that describe the differences between the conventional and the Samaritan donation experience. At present, data seem to be accumulating that support the view that Samaritan donation leads to satisfactory outcomes in terms of the psychological health of these donors (Jacobs et al. 2004; Gilbert et al. 2005; Morrissey et al. 2005; Garvey et al. 2006; Jendrisak et al. 2006). Nevertheless, data are still limited, and numbers are not large enough to be fully convincing of the absence of adverse psychological outcomes for Samaritan donors. Furthermore, most experience in this field is from the USA. Professionals from Europe seem more conservative about this type of donation, and consequently fewer results have been published (Hoyer, 2003; Omnell Persson et al. 2007; Zuidema et al. 2007). Whatever our decisions as to whether or not to accept someone as a Samaritan kidney donor, and whatever the consequences of these decisions, we would like to encourage the exchange of information so that we can learn from each other’s experiences in this developing clinical field in regard to the criteria that can best be applied for the evaluation of Samaritan donors.

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Declaration of Interest

None.

References


