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Help Me Help You! Employing the Marketing Mix to Alleviate Experiences of Donor Sacrifice

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Abstract

Nonprofit organizations often rely on individuals to execute their mission of addressing unmet societal needs. Indeed, one of the most significant challenges facing such organizations is that of enlisting individuals to provide support through the volunteering of time or donation of money. To address this challenge, prior studies have examined how promotional messages can be leveraged to motivate individuals to support the missions of nonprofit organizations. Yet promotional messages are only one aspect of the marketing mix that may be employed. The present study examines how donor-based nonprofit organizations can employ the marketing mix—product, price, promotion, place, process, and people—to influence the experiences of sacrifice associated with donation. The authors do so through an ethnographic study of individuals participating in living organ donation. First, they identify the manifestation of sacrifice in donation. Next, they define three complementary and interactive types of sacrifice: psychic, pecuniary, and physical. Then, they articulate how the marketing mix can be employed to mitigate experiences of sacrifice that emerge through the donation process. The authors conclude by discussing implications for marketing practice and identifying additional research opportunities for sacrifice in the realm of donation.

Keywords

charitable giving, marketing mix, organ donors, place, price, product, promotion, sacrifice

Nonprofit organizations contribute $985.4 billion to the U.S. economy (McKeever 2018) and serve the public interest by providing a wide array of crucial services, goods, and resources—from food and shelter to body parts. Organizations tend to employ the promotion element of the marketing mix to persuade individuals to donate; however, there may be opportunities to use additional elements. The greatest challenge such organizations have in executing their missions is that of securing sufficient donations from individuals (Bendapudi, Singh, and Bendapudi 1996; Winterich, Mittal, and Aquino 2017). All types of donations from individuals entail sacrifice, yet those who provide anatomical parts in support of health care treatments make undisputed sacrifice. Because not all donations are born of the same degree or type of sacrifice, it is necessary to understand sacrifice in relation to donation so that organizations can better overcome this obstacle when recruiting donors. Thus, the question guiding this research is, How can organizations use marketing-mix variables to reduce experiences of sacrifice in donation?

Studies on consumer shopping behavior have focused primarily on the monetary sacrifice made to obtain value imparted by organizations through the marketing mix (Gupta and Kim 2010; Howard and Kerin 2006; Jindal et al. 2020); in contrast, the charitable giving literature has focused on promotion to increase the number of donors and size of donations (Fajardo, Townsend, and Bolander 2018; Liu and Aaker 2008; Reed et al. 2016; Winterich, Mittal, and Aquino 2013, 2017). Although there is recognition that the elements of the marketing mix influence shopping behaviors (Jindal et al. 2020), there is little insight into how marketing-mix elements—product, promotion, price, place, process, or people—may be employed to support charitable giving. While promotion to attract donors is certainly important, it is likely insufficient to convey the full complement of donations needed. Consider, for example, the variance in degree of sacrifice sought. For some organizations, little effort is required (e.g., church usher, PTA member, Meals on Wheels driver); for others, the sacrifice is more extensive (e.g., Make-A-Wish granter, foster parent, organ donor). The present study examines living organ donation, a process in

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which one undergoes elective surgery to remove an organ for transplantation into another person. Given that any kind of organ donation represents an extreme form of sacrifice, the transplantation phenomenon serves as an excellent focal point for examining the sacrificial burdens involved in donation and opportunities to overcome them through the marketing mix.

This research suggests that different elements of the marketing mix may be used to address sacrifice related to donating behavior. Our findings suggest that a combination of marketing-mix elements may reduce experiences of sacrifice and thereby increase donation behaviors. This research contributes to literature recognizing that consumer reluctance to donate must be overcome (Fajardo, Townsend, and Bolander 2018; Liu and Aaker 2008; Reed et al. 2016; Winterich, Mittal, and Aquino 2017). This reluctance has been addressed by prior research, which has emphasized that promotional messages may be used to procure necessary donations. This study extends scholarship on donation by leading our inquiry beyond that of promotion. Specifically, we describe how sacrifice manifests in the donation process and identify roles for the marketing mix to overcome potential reluctance to make such sacrifices. Relevant to an examination of marketing mix are such variables as product, price, place, process, people, and promotion.

In addition, this research contributes an understanding of anatomical parts as a particular type of possession separate from money, time, or other objects. While the donation of anatomical parts has been explored in the social sciences (Sharp 2006; Strathern 2012; Titmuss 1997), it is not a focus of marketing literature, though the market for such parts is significant and growing. This research also contributes an understanding of how nonprofits may attract organ donors by more intentionally and systemically overcoming concerns of potential donors. Where prior research has considered donations of money, which can be replenished (Lee and Bradford 2015; Liu and Aaker 2008); possessions for which individuals have sentimental attachments (Winterich, Mittal, and Aquino 2017); or time, for which all individuals have the same irreplaceable amount each day (Reed et al. 2016), this research investigates the growing market of anatomical parts for transplantation.

In addition, this study offers practical applications by suggesting how marketing-mix elements can be employed to overcome the barriers that may hinder individuals from donating. By better understanding how individuals may experience sacrifice through donation, we provide insights and tools for nonprofit managers focusing on how to use the marketing mix to encourage donation and thereby increase supply to meet demand.

To contextualize this study, we begin with a succinct review of the marketing and social science research on donation and sacrifice. We then present our methodology, including an overview of living organ donation within the U.S.-based transplantation market. We close with our findings, followed by a discussion of implications for practice and theory.

Theoretical Background

Nonprofit organizations deliver services to their clients made possible through donations from individuals (Bendapudi, Singh, and Bendapudi 1996; Winterich, Mittal, and Aquino 2017). These donations are depicted as gifts of "life" or "hope" that support others in need (Sherry 1983). Such donations are most often provided by individuals who intentionally offer their support without receiving tangible rewards (Gershon and Cryder 2018; Peloza and Hassay 2007; Titmuss 1997; Wilson 2000; Wymer and Samu 2002). These donations can be categorized as gifts to society that encompass the sacrifice of forgone opportunities (Larsen and Watson 2001; Mauss 1967; Strathern 2012). It is worth noting that these contributions are substantively distinct from contributions made to obtain some benefit for the self, such as with "pay what you want" pricing approaches (Christopher and Machado 2019). More specifically, contributions to nonprofit organizations are most often provided to deliver a benefit to others. Next, we provide a brief review of the marketing literature on donation and sacrifice.

Donation

Marketing and consumer researchers have primarily examined how the promotion element of the marketing mix can be employed to attract donors and increase donations. Studies provide insight into how messages may influence potential donors, turning a lens on the relative importance of the help sought (Fisher and Ackerman 1998), the role of individual identity (Bradford and Lee 2013; Reed, Aquino, and Levy 2007), the motives for participating (Wilson 2000; Winterich, Mittal, and Aquino 2013), or the impact on the donor (Fisher and Ackerman 1998; Winterich, Mittal, and Aquino 2013). The focus of those studies has been to identify and understand conditions by which appeals may arouse sufficient interest for individuals to donate to an organization. Although promotion has a role in transforming individuals into donors, prior research does not illuminate how coupling other marketing-mix elements together with promotion may influence donation.

Awareness of opportunities is an important factor in securing donations, particularly in the case of organ donations (Healy 2006; Waldby and Mitchell 2006), and leads many organizations to focus on promotion. Knowledge acquisition is certainly a contributing factor for those who choose to donate anatomical parts, yet additional requirements are necessary to transform them into donors. For example, even after passing the first hurdle of developing a desire to donate, potential donors must still qualify to participate (Bradford 2019; Titmuss 1997). Thus, it is necessary to investigate the donation experience to better understand the marketing mix's role in attracting and securing donors.

Donations to organizations have been viewed as gifts to society (Bradford 2013; Strathern 2012; Titmuss 1997). Like other types of gifts, these are born of sacrifice (Mauss 1967; Sherry 1983). Importantly, not all donations involve the same degree of sacrifice, as individuals possess several resources

they may gift as donations. There are monetary gifts, which are viewed as replenishable and fungible. There are gifts of time, something qualitatively different from money in that time may not be stored or replaced (Fisher and Ackerman 1998; Holbrook and Lehmann 1981). Other possessions that may be donated have value in the degree and source of individuals' attachment to them (Belk 1990; Winterich, Mittal, and Aquino 2017). Lacking in this conversation is an understanding of how the marketing mix can address the types or degrees of sacrifice that may be associated with the donation of possessions.

Sacrifice

In the marketing literature, the concept of sacrifice is focused primarily on price—what consumers give up to obtain value (D'Angelo, Diehl, and Cavanaugh 2019; Gao, Zhang, and Mittal 2017; Zeithaml 1988). Beyond money, research identifies consumer sacrifice as the expending of energy, effort, or time (Baker, Grewal, and Voss 2002; Bender 1964; Bradford and Sherry 2013; Gupta and Kim 2010; McGrath, Sherry, and Levy 1993). The degree of sacrifice, conveyed by price, may serve as information to consumers (Dodds, Monroe, and Grewal 1991; Gao, Zhang, and Mittal 2017), inform perceptions of alternative offerings, or provide indicators of offering quality (Suri, Kohli, and Monroe 2007; Völckner 2008). In addition to the sacrifice one may make to obtain an offering, there is the sacrifice that manifests as a consequence of forgoing other options (Larsen and Watson 2001; Völckner 2008). While individuals may feel minimally burdened by the particular form of sacrifice made, some sacrifices may be deemed too great, thereby reducing a consumer's willingness to purchase an offering (Belk and Coon 1993; Dodds, Monroe, and Grewal 1991). While price is often equated with sacrifice in the market, there also is recognition within the literature that consumers make sacrifices beyond price to attain desired outcomes.

Extra-economic sacrifices are found in investments of time, effort, or energy (Areni, Kiecker, and Palan 1998; Belk and Coon 1993; Fernandez and Lastovicka 2011; Gupta and Kim 2010; Zeithaml 1988). Time is a limited and perishable resource. It is most often viewed as that which may be monetized and is perceived as a cost (Baker, Grewal, and Voss 2002; Giebelhausen, Robinson, and Cronin 2011; Zeithaml 1988), considered in relationship to search and intended patronage (Baker, Grewal, and Voss 2002; Grewal, Monroe, and Krishnan 1998), or viewed as a precursor to attaining desired offerings (Bradford, Grier, and Henderson 2012; Howard and Kerin 2006). As a type of sacrifice, time is often described in conjunction with effort. Sacrifices of effort are depicted as labor or inconveniences necessary to attain benefits (McGrath, Sherry, and Levy 1993; Otnes, Lowrey, and Kim 1993). Effort is evident in the cocreation of market-derived experiences where consumers are active participants (Celsi, Rose, and Leigh 1993; Epp and Price 2011; Scott, Cayla, and Cova 2017; Tumbat and Belk 2011). Sacrifices of effort may include that of choice when individuals opt to provide gifts in response to specific recipient requests (Bradford and Sherry 2013; Lowrey, Otnes, and Ruth 2004; Wolfinbarger 1990).

Sacrifices of energy are described as psychic or emotional expenditures encompassing the contemplation associated with a consumption opportunity (Areni, Kiecker, and Palan 1998; Aydinli, Bertini, and Lambrecht 2014; Baker, Grewal, and Voss 2002; Belk 1996). While a primary focus in the literature is on monetary sacrifice for value that is conveyed through the marketing mix, it is necessary to examine how the marketing mix can be used to address sacrifice experienced by donors. Although time and effort may emanate from the embodied self, sacrifice of the physical self is less often contemplated. Nonetheless, Fernandez and Lastovicka (2011) examine the employment of physical and mental energy to transform a previously used object; Marcoux (2009) considers the physical nature of effort involved in providing relocation assistance; and Klein, Lowrey, and Otnes (2015) recognize the physical peril individuals accepted when they secretly shared additional food with other inmates in Nazi concentration camps. Together, those findings illustrate that monetary sacrifice alone may be insufficient for some forms of consumption and that promotions are likely insufficient to overcome sacrifices beyond those of awareness.

Methodology

The purpose of this study is to understand the nature of sacrifice in donation so as to guide organizations in overcoming obstacles to obtain donations. Because living organ donation indisputably involves great sacrifice, it provides a clear context in which to understand sacrifice in relation to donation. Furthermore, an organ must be donated voluntarily and may only be offered as a gift in the United States (National Organ Transplantation Act of 1984; Uniform Anatomical Gift Act of 1968[1]). Next, we provide an overview of the phenomenon followed by a discussion of data collection and analysis.

Phenomenon of living organ donation

Living organ donation is orchestrated by medical personnel and associated transplant centers within the transplantation market. Whereas early transplants relied on organs from deceased individuals, living organ donation is increasing as health care innovations provide opportunities for transplanting organs from living, genetically unrelated individuals (Bradford 2013; Rothman, Rozario, and Rothman 2007). Nonetheless, with demand for organs outpacing supply, living organ donors are increasingly sought. Without a transplant, individuals experiencing organ failure may undergo various treatments that sustain life, though often at diminished quality. All clinical costs associated with donation are funded by participating organizations (e.g., organ procurement organizations, insurers, transplant centers

[1] See https://www.uniformlaws.org/committees/community-home?CommunityKey=015e18ad-4806-4dff-b011-8e1ebc0d1d0f (accessed March 5, 2020).

within hospitals) and are coordinated by a transplant team (Waldby and Mitchell 2006).

Individuals may donate one kidney, a portion of their liver, a lung, or part of their intestine. We study the experiences of living kidney donation, as they are the most frequent type. The organ donation process is complex, requiring physiological and psychological clearances of donors. Living donors may be directed, meaning they donate to a known other (e.g., loved one, colleague), or nondirected, thereby donating to an unknown other. Nondirected donors provide an organ to the next individual on the transplant list with whom they are a match, or to support a donor chain. No matter the recipient, the donation process is the same.

This process begins with education and culminates with surgery. The organ donation and transplantation process includes informing potential donors about the steps to qualify and the consequences of participation. Once they choose to participate in the process, individuals are assessed for their overall fitness. Qualification begins with procuring an extensive medical history, which provides for an assessment of overall health as well as evidence of current and potential (physical or mental) disease. Next is tissue and blood testing to assess the viability of a match to a recipient. When an individual is identified as a clinical match to a recipient, and it is determined that removing the organ is not likely to be detrimental to the donor, surgery is scheduled.

Kidney transplants occur across two surgeries. First is the nephrectomy, removal of the kidney from the donor, a surgery that typically lasts four hours. Next is the transplantation, the insertion of the donated kidney into a recipient, which lasts approximately three hours. Surgery leaves a donor with an immediate and significant degradation of bodily functionality, coupled with the physical trauma of the procedure. Donors are hospitalized on average between two and four days after the procedure, followed by a recovery period at home of two to six weeks. Recipients often emerge from surgery feeling well due to the immediate functionality provided by the transplanted kidney. Both parties are required to participate in follow-up tests to monitor their respective kidney function, though the requirements differ.

Data collection

Because the present study focuses on the experience of living donation, we deemed ethnography to be the most appropriate research method. Given that the process to become a living organ donor is quite extensive, a larger number of people begin the screening process than actually donate. This is due to any number of reasons, including a prospective donor's current or projected health, willingness to proceed through various clinical tests, or decision to terminate the process. To better understand sacrifice within living donation, this study thus examines only those individuals who completed the living kidney donation process.

Prior to beginning this study, the authors themselves participated in organ transplantation. The second author made her need known, as advised by her physician. The first author volunteered to be tested and ultimately became the second author's donor. The process, from the precipitating event through recovery, transpired over a period of nine months. Each author recovered without incident. Throughout this process, field notes were captured.

Study participants were solicited through clinicians, online living organ donor support forums, and snowball sampling, with varying outcomes. They included individuals from different regions in the United States who participated in both directed and nondirected donations. Each author has a relationship with a nephrologist (kidney physician) with whom they shared the intention of this study. Those physicians were asked to share study information with their patients as they saw fit. The physician provided those patients who expressed an interest in participating in this study with the authors' contact information. Within online donor forums, the first author posted notices inviting willing participants to initiate contact through a social media platform, direct message, or email. In both recruiting approaches, more individuals expressed interest in participating in the study than actually followed through to participate in interviews. No compensation was provided to individuals who participated in this study.

Our sample includes 20 individuals representing diversity in race, age, sex, sexual orientation, elapsed time since donation, donor and recipient outcomes, type of donation (i.e., directed, nondirected, or donor chain), and location (see Table 1). The participants include eight nondirected donors and six individuals who had complications or became aware of their recipients' complications. Although statistics indicate that the majority of donors continue to be in good health postdonation, some suffer donation-related complications. Our participants' clinical outcomes range from expected recoveries to varying degrees of acute or chronic physical and emotional disease. Most, but not all, recipients had resumed a healthy lifestyle free of dialysis.

We collected ethnographic data through semidirected phenomenological interviews, participant observation in living donation, and online donor forums. We downloaded the posts of individuals identified in online forums, which often provided an archived timeline of their experience, and these served as projective tasks within interviews. Given our own experiences, we quickly established rapport with study participants.

We began interviews by asking individuals to describe how they became a living organ donor. Accounts shared in response to the initial question were probed using emic terms to facilitate interview continuity. In addition to learning of each unique circumstance, we asked individuals to describe how they learned of the need, made the choice to donate, and experienced testing, surgery, and recovery. They were also asked to describe the process, who was involved in the process, the emotional and physiological outcomes for themselves and the recipient (when known), and the timing of the transplant. Interviews ranged in duration from one to four hours, with an average of 90 minutes and some follow-up exchanges on social media and email. Data were collected by phone and through

Table 1. Overview of Study Participants.

Pseudonym	Sex	Age (Years)	Type of Donor	Donor Outcomes	Recipient	Recipient Outcomes
Alison	Female	40s	Nondirected	As expected	Stranger; different race	As expected
Derrick	Male	50s	Directed	As expected	Wife	As expected
Erica	Female	30s	Nondirected (paired kidney program)	As expected	Mother	As expected
Franklin	Male	70s	Nondirected	As expected	Stranger; met after 15 months	As expected
Gregory	Male	60s	Directed	Chronic pain	Colleague's daughter	As expected
Hannah	Female	50s	Directed	As expected	Neighbor; developed relationship with extended family	Kidney died; recipient went on dialysis
Isaac	Male	40s	Directed	As expected	Professor; reconnected via Facebook	As expected
Jacob	Male	50s	Directed	Surgical complications, financial complications	Coworker; different ethnicity	As expected
Kenneth	Male	40s	Nondirected (donor chain)	As expected	Stranger	As expected
Lizbeth	Female	40s	Directed	As expected	Brother	As expected
Meredith	Female	50s	Directed	As expected	Son	As expected
Nancy	Female	50s	Directed	Depression, kidney disease	Friend	Continues to have health challenges due to chronic disease
Octavia	Female	40s	Directed	As expected	Mother	As expected
Penelope	Female	40s	Directed	Initial complications due to previous surgery; recovery as expected	Brother	As expected
Quintessa	Female	30s	Directed	As expected	Husband	As expected
Reginald	Male	50s	Directed	As expected	Brother	As expected
Sadie	Female	60s	Directed	As expected	Husband	Less than half normal activity resumed
Tabitha	Female	20s	Directed	As expected	Cousin	As expected
Victoria	Female	50s	Directed	As expected	Niece	As expected
Wilma	Female	50s	Directed	As expected	Brother	As expected

face-to-face meetings at the convenience of participants. Interviews were audiotaped and transcribed.

Data analysis

Interview transcripts and field notes provide the basis for our analysis and interpretation. Data analysis began with a review of the donation process as described by donors. This review revealed that the donation process was the same for all participants regardless of center type, testing protocol, or surgical method, thus allowing for comparison across phases in the process. Next, codes were generated from readings of the anthropology, theology, market, and consumer research on donation (e.g., time, money, effort). Those initial codes were supplemented with emic terms (e.g., wait, goal, endure) from the initial analysis of the transcripts and field notes.

Analysis continued with each transcript being coded. Next, transcripts were analyzed across each phase of the donation process: learning about the opportunity, making the choice to participate, qualifying (i.e., determining the degree of match), and fulfilling the commitment to volunteer (i.e., surgery, recovery, and donor outcomes). In addition, we analyzed transcripts across outcomes in terms of meeting expectations (e.g., successful outcome), exceeding expectations (e.g., easier, faster), or falling below expectations (e.g., poor outcomes for the self or the recipient). Thus, two types of analyses—diachronic (i.e., across the process) and synchronic (i.e., within similar phases or outcomes of the process)—were performed (Arnould and Wallendorf 1994; Strauss and Corbin 1998; Thompson 1997).

We identified emergent themes through an iterative process comprising analysis of the transcripts, the coded data, and the literature (Strauss and Corbin 1998). Data collection and analysis continued until saturation was attained. We conducted member checking in follow-up discussions and emails with four participants.

Findings

We codify the living organ donation process in three key phases: deliberate, decide, and donate. Through our participants' experiences, we find that the marketing mix is the

Table 2. Definitions of Sacrifice as Experienced Across the Three Phases of the Donation Process.

	Psychic	Pecuniary	Physical
Deliberate	Mental effort to consider the option	Expenditures associated with exploring the opportunity	Behaviors or actions exerted to assess opportunity
Decide	Mental energy to weigh benefits and concerns of selection	Expenses related to choosing to pursue an opportunity	Behaviors or actions employed to choose an opportunity
Donate	Recognition that a choice removes other possible choices	Costs incurred with making the contribution	Being present to provide contribution

primary means by which organizations may support the donation process and, in particular, mitigate donor sacrifice that emerges as individuals become donors who offer their possessions for the benefit of others. We identify roles for six marketing-mix elements that aim to manage sacrifice experiences: product, promotion, place, price, process, and people. Furthermore, we identify three complementary and interactive types of sacrifice: psychic, which reflects the employment of mental or emotional energies; physical, which encompasses investments of components and functioning of the bodily self as well as modifications to behaviors; and pecuniary, which comprises investments of possessions, time, or money. We find the each of the three types of sacrifice may emerge during any of the phases within donation (see Table 2).

In line with this categorization, we find that there may be opportunities for organizations to address the types of sacrifice that may evince across any one of the three phases of the donation process. While both individuals and organizations participate in each of the phases in the process, the degree of relative influence varies, such that the deliberation phase is more heavily influenced by the individual and the donation phase by the organization. Next, we depict participant experiences through data excerpts to illuminate relationships between sacrifice and the marketing mix within each phase of the process. Although the phases are presented as discrete units, the experience is more of a continuum in that data may encompass aspects of more than one phase.

Deliberate

The first phase in the process is one of deliberation, in which organizations prominently employ promotion to raise awareness of the donation opportunity. For many donor-reliant organizations, the product and process are entwined in delivering the intended outcomes and associated benefits. Here, too, we find that organizations may benefit when they more fully depict the product as comprising both the donation and the transplantation. Through our informant experiences, we identify roles for the product and the process that, together, provide donors with opportunities to contemplate the benefits and risks of participating (for themselves and for the recipient). The participants in our study come to learn of this particular volunteer opportunity in a variety of ways, from observing a loved one's decline in health to encountering promotional (and public relations) messages. Regardless of the means through which individuals learn of the donation opportunity, they necessarily employ psychic sacrifice to better understand the requirements and implications of participation in the process.

One informant, Gregory, initially learned of living organ donation through a story on National Public Radio's *This American Life* program. He describes how that story prompted him to consider participating as a living organ donor, though he was not moved to act until he received a request for help. While promotion stirred his interest in the product, it was insufficient to motivate action to participate. He learned, through a group email, that his colleague's daughter was diagnosed with end-stage renal disease and was a candidate for transplantation. Though he did not know the daughter, he describes feeling compelled to offer to become her donor:

> I received an email from [a colleague] on a Sunday morning that his daughter had just gone onto the transplant list. . . . It was a request [saying] that she needed a kidney—he was letting other people know. And [the email] stated her blood type, and it was mine. I spent about an hour wrestling with it, looking for a justifiable reason not to volunteer. And finding none, I decided that I would volunteer to be tested. (Gregory)

The information from his colleague, coupled with knowledge garnered from a donor story in the media, compelled Gregory to donate. He describes learning of the opportunity to act along with the awareness of the product and process as integral to awakening his calling. Gregory's acknowledgment of his calling encompasses psychic sacrifices with respect to relinquishing a sense of control over the choice to participate. His sacrifice of choice was not due to any external forces but, rather, an alignment of his choice with his calling.

Within the deliberation phase, individuals acquire additional knowledge about the process by which the donation will be used to deliver the product and associated benefits for the nonprofit's client. For most of our informants, the initial information requests are related to the specifics of donation in terms of what they contribute to the product and the process. That often begins with a desire to understand the requirements necessary to participate:

> I called [a transplant center in my city] just to see if I was even a candidate. . . . I was going to be 61 in February, and I thought quite possibly I would be too old. They said that because of my age I would be considered a marginal donor in their system. I called [another transplant center] where the surgery was to be performed

> and they said, according to their system, I was fine. So, I began the long evaluation process. (Gregory)

Across transplant centers, the product—retrieving a donated organ and transplanting it into one in need—is the same. Gregory pursued the donation opportunity in the face of mobility challenges, legal blindness, and the concern that he may be too old to participate. In fact, when he presented himself to a local center as a donor, he was rejected due to age. While it is uncommon for individuals to comparison shop for a transplant center, there are several instances in our data in which individuals found aspects of a center's process or people to more readily mitigate sacrifices posed by the donation. Thus, individuals might find one center to be more attractive than another, which may influence where or how they choose to participate.

When individuals learn about donation opportunities through intimate relationships, as is the case with a spouse or siblings, they may experience a strong desire to donate even before fully understanding the product, process, or its impact on them. That desire also has the potential to stir psychic sacrifice as individuals pursue a known product with little information about the process around it. Wilma's brother was in need of a kidney, yet she had little understanding of what would be required of her. The transplant center personnel began educating Wilma from their first conversation when she requested information on how to become her brother's donor:

> I just called [the center], and [the transplant coordinator] sent me out my package and we went from there . . . . I think [my brother and sister-in-law] wanted to control [the process]. I think they just found out that [the transplant center] wasn't going to let them control it anyway. Their blind selection of a donor was to protect both ends, both the recipient and the donor. I felt very . . . taken care of, very considered. They were always looking out for me. They said, "You can stop this process any time you want. Even if you're a perfect donor and you get the heebie-jeebies, it's okay, you can stop it." . . . I knew at any time I could say no and so, therefore, I didn't feel like I wanted to say no. . . . They were very kind, they were very helpful, very professional . . . . We do feel like we've been on a ride and I think it's not just me, 'cause I'm the donor. But it's the whole family—my dad, my brother Bill—just all of us feel like this has been a long process. (Wilma)

As Wilma's knowledge increased, so did her comfort with donation. From the initial stages of the process, the people responsible for facilitating the process to deliver the product conveyed the ways in which they would help Wilma navigate and support her through the process. The people and their focus on Wilma's well-being helped mitigate experiences of psychic sacrifices even before they emerged.

Promotion focuses predominantly on why one should donate, not on how messaging can help attenuate the psychic sacrifices individuals may make as they navigate relationships affected by donation. For example, an individual's decision whether to donate an organ can have major relational impacts within their network of family, friends, supporters, and naysayers due to the potential health risks and uncertain recovery period involved. Consider the experience of Gregory, who terminated his relationship with his longtime partner when she questioned his desire to donate. In addition to supporting potential donors, it is crucial for the process and promotion to attend to the support network of those donors. An example is found in Wilma's experience, in which she describes how the people in the center focused on communicating the process and her role within it to deliver the product as support for her as well as to alleviate her family's trepidation. Then there is Nancy, who incurred travel costs because she felt the need to communicate to her family in person regarding her intention to donate. The people in Nancy's center were less helpful in supporting her desire to understand the process in detail, which resulted in her incurring financial costs. Perhaps if the people and process were more supportive, Nancy would have been able to avoid pecuniary sacrifices in support of her donation.

The process tends to focus on the potential donor, with some inquiries about their support system. This approach in organ donation is derived from laws that prohibit the sharing of medical information with people other than the patient. While legally compliant, such an approach often leaves potential donors lacking in assistance as they attempt to encourage their support system to come on board. Consider another informant, Kenneth, who described his wife's dismay as he aimed to initiate a kidney transplant donor chain. A donor chain is possible when donor–recipient pairs who are not clinical matches participate as part of a group of donors and recipients, where each donor contributes to another recipient such that at least two transplants result (Bradford 2013). Kenneth knew he had an opportunity to positively affect many lives through participation in the chain, as his donation would make subsequent transplants possible. He explains that he put his marriage at risk as a result of his decision to donate:

> I was part of the biggest chain that has been so far. . . . I knew that I was starting it. . . . I'm married and my wife told me she was going to leave me if I did it. I said, okay, and she didn't [leave me]. But I wasn't going to let that stop me because she's worried or whatever. I wasn't going to let that stop the benefit that it was going to be to other people, I didn't think that was right . . . . She never came around . . . . I think it still kind of bugs her that I went against what she wanted. Almost in a way, it's like I had an affair or something. (Kenneth)

Potential donors often invest mental energy when contemplating becoming an organ donor and speaking to their close circle about it. The possibility that their health could be negatively affected may well produce personal stresses and, as was true for Kenneth, stress within their close relationships. Kenneth was driven to contribute what he perceived as the immeasurable good that would emanate from his cumulative psychic and physical sacrifices, and therefore he excluded his wife from a life-altering decision. He draws parallels between his kidney donation and an affair, a state of emotional and/or physical

perfidy. Reconciling this requires him to sacrifice his wife's opinion and support, which are of great value in a peaceful marital union. Yet Kenneth, akin to many of our study participants, describes positive aspects that emerge through donation. The codification of those experiences would serve organizations in the development of promotions and process components to support potential donors and their support systems, as well as infuse opportunities within the process and the people supporting it to celebrate such experiences.

The experiences of the previous informants underline how promotion, designed as it is to disseminate knowledge to potential donors about the opportunity to donate, is insufficient in addressing the various types of psychic sacrifice that emerge through the donation process. The process contemplates the clinical needs of an individual, yet organizational managers should consider and prepare for the types of psychic sacrifices donors make, from contemplating the opportunity, informing loved ones of their decision, and navigating support throughout transplantation, including the postdonation phase. There are a variety of products for which marketers commonly address potential fears (e.g., "safe when used as intended"). Because messaging around organ donation does not typically address the various sacrifices that manifest, there is a large window of opportunity for tailoring the marketing mix to address this deficiency.

The integration of promotion, product, and process also provides opportunities for organizations to support potential donors as they contemplate engaging in donation. Another participant, Sadie, learned of her husband's need for a transplant when accompanying him to a doctor's visit. During that discussion, she learned about and was motivated to consider becoming her husband's living organ donor:

> When you live with someone and all of a sudden you see them losing weight, you see them walking around like a zombie having no energy. . . . He was doing the peritoneal dialysis, and he had to hook himself to the machine every night by eight o'clock . . . . The reason [the medical team] did this for him was because he liked to play golf. They were trying to make it so that he could maintain his lifestyle . . . . He was on dialysis for six months, but it was an awful six months . . . . When I went with him [for a checkup], the nephrologist informed me that a lot of wives are giving their husbands kidneys . . . . I thought, "Well, I have one foot in the grave and one on a banana peel. I can do this!" (Sadie)

The same medical team that proffered in-home dialysis to address her husband's renal failure also offered organ donation as an alternative. The physician shared the benefits of living organ donation and also began to introduce information to enable Sadie to ponder such an option. Even though it was a more complex offering than dialysis, she welcomed an opportunity to take a more active role in improving her husband's health. When discussing it as a family, their son offered to donate instead of Sadie. She declined his offer as he was recently married, had a newborn, and had just started a new career. Thus, she enacted psychic sacrifice in her assessment of the opportunity, the relative risk to the possible donors (i.e., herself vs. her son), the potential impact to her own health, and the hope to enjoy a more spontaneous and active life than that which dialysis accommodated. These sacrifices are not accounted for within the process, leaving donors to manage them on their own when organizations can anticipate such experiences and should proactively address them.

The deliberation phase is likely inspired, in some part, by the promotional element of the marketing mix. However, it is insufficient to address the multifaceted experiences of psychic sacrifice individuals bring to the deliberation phase. Prior research has found that psychic sacrifice may be enacted in response to promotional messaging. For example, a recent University of Pittsburgh Medical Center (UPMC) television commercial depicts a line of individuals slowly making their way through an ominous tunnel with the voiceover: "At UPMC, living donor transplants put you first so you won't die waiting." Similarly, the National Kidney Foundation initiated the promotion "#BigAskBigGive," which provides individuals with guidance on how to talk with others about becoming a living donor. Promotional materials serve to inform, persuade, and invite action by individuals to consider participating in a process to deliver a specific product. Similar to for-profit organizations, which must align promotions with other aspects of the marketing mix, it is necessary for donor-reliant nonprofits to consider how other aspects of the marketing mix can be employed to address psychic sacrifices that may emerge in the deliberation phase of donation. Potential donors experience psychic sacrifice in contemplating what it means to undergo an elective surgery where the result is to remove functionality from their physical self and provide that functionality to another. Psychic sacrifices also serve as precursors for other types of sacrifices to manifest. Importantly, the mitigation of psychic sacrifices through a clearly and compassionately positioned and communicated product and process may provide encouragement to individuals to proceed to the decision and donation phases of the process—phases that likely require additional forms of sacrifice for which donors will seek support.

Decide

Individuals undergo the decision phase of the process as they review the donation opportunity and determine their plans. While organ donation for transplantation, as a product, consists of a similar set of criteria and testing protocols across transplant centers and a consistent set of surgical procedures, there are some differences. These differences reflect each organization's approach to organ donation—specifically, the approaches of those with distinct roles associated with the entirety of the transplantation process. As individuals decide whether to donate, they assess not only the opportunity but also the organization. Thus, the decision to donate may be influenced by aspects of the product, the process to deliver it, the people who enable its delivery, and the place where the donation will occur. Where psychic sacrifice allows individuals to move forward with sincere contemplation, the decision phase finds

individuals facing psychic, pecuniary, and physical sacrifices. Organizations have opportunities to mitigate these sacrifices, thereby likely contributing to the experience of donors and perhaps increasing the likelihood that individuals will choose to become donors.

The opportunities for donor-reliant organizations to employ product, process, and people aspects of the marketing mix become more impactful as individuals assess the opportunity to make their decision. One informant, Penelope, donated to her brother after he survived a failed transplant from a deceased donor. She and her family were angst-ridden by his tenuous health and recount being summoned to the hospital because his physicians were uncertain if he would live. She aimed to better understand the impact of donation as part of the product, as well as the implications of participating on her lived experience:

> [The transplant center] had a reception for donors and recipients, a little cookie and cake thing where people who had [volunteered to donate] talk to those of us who are going to do it. [They] talk about their experience. That was great because I got to see people who had done it . . . . I was getting nervous. I was excited because I was going to help my brother but I was still nervous. That was my first surgery ever. (Penelope)

In Penelope's case, the organization provided individuals considering where to donate an opportunity to learn about the experience from former donors. Sponsoring this event also provides an opportunity for the organization to help donors manage experiences of psychic sacrifice as they weigh saving another's life while risking their own. By expanding the process to include additional people, the organization has opportunities to provide additional support to potential donors and perhaps improve their decision process.

The contributions of an organization's people in the decision phase are crucial to the process and to the donor's perceptions of it. Individuals who choose to donate, as well as their friends and family, may question the extent to which organizations recognize the depth of sacrifices required to do so. Wilma and her husband wanted to learn how people in the organization, and in particular the surgeon, viewed the process:

> My husband asked a question, "What does that feel like once you take that kidney out of there and you take it over to the other person? How do you feel about it? . . . Do you kind of feel like God? Like you're saving this person's life?" [The surgeon] said, "Well, I am the physician who takes out the kidney. My patient is the donor. And, the donor comes in healthy. . . . I am very particular about my job, because in the whole hospital, I'm the only person with patients who come in healthy and go out impaired." And I thought, "Wow! He understands." . . . I felt relieved or assured by him saying that. I knew that he understood the gravity of the donation. (Wilma)

Individuals considering donation recognize that transplantation provides significant benefits for both the recipient and the organization. However, potential donors are acutely aware that those benefits emerge through their sacrifices. As Wilma shared, individuals may encounter compassion in those who play roles in the provisioning of transplantation or in their initial contact with the organization. Such experiences facilitated by organizations through the people and processes that support the product allow individuals to receive validation of their sacrifices and enable their willingness to contribute the sacrifices required to fulfill the donation.

With a decision to donate made, individuals begin the qualification phase. Potential donors are provided a detailed description of the process, including an overview of the criteria required for participation, the testing sequence, and the possible consequences of participation. The choice to donate is fraught with uncertainty, as it does not mean that an individual will be accepted as a donor. As such, individuals have different approaches to sharing their intentions with others. The first author described angst when contemplating with whom to share:

> I want to tell [my friend] about my plans [to donate]. She might think I'm crazy. I can't hear anything negative about [donating]. It's enough that [the transplant coordinator] said I could die! But what if [the transplant center] rejects me? How will I explain that? (Field notes)

It is commonplace for individuals to share important happenings in their lives with others. The desire for acceptance of one's decision and support for it is common among the participants in our study, and many seek out such support in online donor forums.

The experience of qualification feels more extensive than how it is presented to potential donors. Participants generally express astonishment at the degree of testing required:

> I thought it was just a blood test. I learned I had more tests to take . . . . I thought, "Oh Lord, this is going to be impossible!" . . . Everything was going along and [the transplant coordinator] came back and said we are an identical match! . . . I think one of the difficult things is we don't know how to ask a sibling to donate. It's a sacrifice. (Reginald)

The transplant coordinator orchestrates progression through the qualification phase based on clinical results from a series of escalating tests (e.g., blood tests to CT scan). These tests may be the first opportunity for individuals to experience the place where their donation will occur and, as such, leaves an indelible impression. One of our informants, Nancy, was deciding whether to conduct her tests at the local transplant center or the one where she was a potential match to a recipient. Ultimately, she felt it necessary to meet the people who would orchestrate and conduct her donation. She organized a visit incurring travel, accommodation, and vacation time costs to travel from one state to another in the Western part of the United States:

> I did online research . . . . The transplant center sent me a [video] and I read the literature that they gave me . . . . I decided to go to [the next state over] where the transplant happened—I wanted to do the blood matching there. . . . I wanted to meet the people . . . . I read the possible adverse effects like pneumonia, blood clots, and death. I felt comfortable, but I still wanted to know more . . . . When I came to the appointment with the transplant surgeon, who's actually a cardio surgeon, he's not even a nephrologist! . . . I had lots and lots of questions. I wanted to know what was going to happen during the surgery and he just kind of waved me off and said, "Oh you don't need to know that; let's not worry about that. We'll take the kidney out of your old caesarean scar. You won't have any new scars and the rest of it we won't worry about." He just wouldn't give any more information and I even asked, "Are there any other living donors? Is there somebody I could talk to?" . . . They said, "Oh no, we don't do that." (Nancy)

As individuals proceed through the process, their awareness of the impending surgery and its associated risks becomes more of a reality. Where Penelope describes an opportunity to interact with former donors, Nancy was not allowed to do so. Thus, process contributed to Penelope's reduction in experiences of sacrifice by enabling her to see former donors, yet it accumulated additional sacrifices for Nancy. Furthermore, where Wilma's experience of sacrifice was attenuated by the health care staff, for Nancy it was not. Although these donors continued through the process, there are opportunities for organizations to mitigate experiences of sacrifice through marketing-mix elements that may also enhance the overall donation experience.

An increasing awareness of the associated risks provides insights into the various sacrifices these individuals undergo. There are two that seem to be most angst producing: (1) the possibility of death and (2) the possibility of being rejected. In Nancy's visit, it becomes evident that although the product is similar, there were opportunities to employ alternatives for the communication of the process as well as interactions with transplantation staff to address her experiences of sacrifice related to her well-being and, ultimately, her life. Other participants spoke of the angst experienced as they pondered whether they would meet the criteria to donate. Participants stated that they have sufficient information about the process from the promotional and product materials as it relates to reasons why they may not be accepted as donors, or the rare but possible outcome of death. Yet their confidence in the process is influenced and experience of sacrifice altered when they are exposed to the people within it.

Throughout the process, individuals often seek some affirmation that everything will work out satisfactorily. That is often evident in how individuals pursue the qualification process. For Nancy, it entailed travel to the transplant center to gather first-hand knowledge of the overall process and people within it. For others, like the first author, there are sacrifices made to ensure success with each step throughout qualification with the hopes of increasing the probability of acceptance. For example, the first author was required to complete the 24-hour urine volume test four times, as the results were different than expected by clinicians:

> Seriously? I drink a *lot* of water—the two jugs [of urine] are *all* mine! Off to get the new jugs and another [urine collection] hat . . . . I don't like the jugs at the [local clinic] so I will get them from the [local] transplant hospital—it's a drive, but anything is better than redoing this test! (Field notes)

Testing often requires that individuals rearrange their lives to accommodate travel, clinical appointments, and testing procedures. As with the surgery costs, tests are covered by the recipient's insurance. However, some of these activities necessitate the expenditure of money (e.g., copay, gas, parking). In addition, the tests themselves typically require that individuals provide access to their body and bodily products to assess fitness for organ donation. Thus, testing to qualify may lead to psychic, pecuniary, and physical sacrifices. These sacrifices emerge during a fragile time in the process when individuals are anxiously awaiting to hear whether they can progress to the next phase of testing until they are accepted as donors.

The nexus between place, people, and process in the decision phase represents an ideal point at which marketers can influence the donation experience. At this juncture, there is an escalation of commitment evident as individuals proceed from consideration to making a decision to actively pursuing the final phase of donation. Alison, a nondirected donor, wanted to donate in response to a story she heard on NPR. She is a busy mom with a career who wanted to donate on her terms. She identified a convenient location for her donation and prepared a schedule that negotiated necessary donation-related time commitments with the demands of her life. Alison describes her experiences of sacrifice and how the organization employed people throughout the process to attenuate anticipated anxiety as she passed from one level of clearance to the next round of testing:

> You kind of felt like you were on the show *Survivor*. Every time [the transplant coordinator] would email or call me, I would be like, "Was our blood a match?" Every time you had to have that blood draw, you were praying that you still were on the island! That you weren't going to get the call, "Sorry, you've been rejected. You can't donate." . . . Every time I knew I passed the next test, I was like, "Yes! Okay! One step closer!" (Alison)

The presentation of the self for extractions of fluids and tissues serves to prepare individuals for ever-increasing physical sacrifices culminating with the nephrectomy. The relationship the transplant coordinator builds with the potential donor is key. The commitment to the process is commonly expressed because individuals anticipate progressing through to the donation stage. Ideally, the transplant coordinator supports this anticipation with commendations as potential donors undergo sequential tests and celebrations when they advance through stages in the process.

The decision phase encompasses the full complement of sacrifices, but psychic sacrifices in particular usher in opportunities for additional experiences of sacrifice as individuals move through different phases. Key to the donation is the integration of process and people (surgeons, counselors, etc.) within place to deliver on the transplantation product. Furthermore, while incurred costs are pecuniary sacrifices, organizations provide a variety of alternatives to help individuals assuage or avoid incremental costs. Doing so likely requires additional donor confidence in the team communicating and managing the process. Within for-profit offerings, sacrifices associated with price may signal desirable attributes (Zeithaml 1988). However, incurred costs within donation tend to reflect a need for organizations to communicate more with potential donors such in order to mitigate such costs. Within the decision phase, donor sacrifices may be managed through a combination of marketing-mix elements to support donors as they make a crucial decision.

Donate

The donation phase is reached when an organization's efforts to secure donors materializes. This phase culminates with the creation of a product (a donated organ for transplant) that provides valued benefits to clients. For those attracted to donate, organizations orchestrate the delivery of the product benefits through place, which houses the requisite people and processes. This phase of living organ donation then concludes with the emergence of the most critical sacrifice: the nephrectomy. While organizations cannot eliminate the totality of sacrifices associated with this phase, they can—through the careful specification of the product including roles for donation and thoughtful facilitation of product delivery through place, people, and processes—attenuate experiences of sacrifice.

As the people within organizations prepare donors for surgery to complete the donation, there is an opportunity to contribute to donor confidence and comfort in order to reduce experiences of sacrifice. Increasing comfort with the part of the process that encompasses the details of surgery is a crucial component of the experience. One informant, Victoria, donated to her niece. Once credentialed as a donor, she recounts how she aimed to gather as much information as possible to better understand how her kidney would be removed:

> I'm one of those people that goes and does as much research as possible. As soon as they told me I was a match, I'm like, "Okay, what's the surgery going to be like?" I actually found on YouTube a video of the actual surgery so I sat and watched that . . . . The surgeon actually has to slide their hand [into the abdomen] to retrieve the kidney . . . . It wasn't long after that I was meeting the surgeons. I met the one gentleman who came in and the first thing I looked at—his hands were huge! I was just like, "Oh my gosh, are you my surgeon?" He says, "No actually, I'm going to do the transplant [into the recipient]." I'm like, 'Oh good!' He kind of looked at me funny, and I said, "Your hands are huge!" Shortly after that, I met my surgeon. It was a woman and she has these beautiful, little, tiny hands! (Victoria)

In the deliberation phase, donors are most often concerned with factors related to transplant center successes. After deciding to pursue donation and being accepted to donate, individuals often turn their focus to the surgical process that results in donation. Like Victoria, donors express concern with recovery and factors that may influence it, including the size of the incision or degree to which organs are displaced. Though transplant centers do not assign surgeons based on hand size (or personality, or specialty area), it is crucial to understand the importance of people within the process. Organizations should have an awareness of what factors may increase perceived donor sacrifice and how they can proactively manage them.

Once in the donation phase, sentiments about completing the process become more salient. Hannah, a hospice nurse who describes herself as one who avoids "medical stuff," describes how interaction with her surgeon reduced her concerns with donation:

> I just love [my surgeon], there was something about him. And surgeons are usually so detached and so task-based. He was just a lovely man. We talked about different ways he could do the surgery. I said, "Well, I'm going to be asleep so I want you to be comfortable with how you're doing this." . . . He did end up doing the open [nephrectomy]. I have a six-inch scar . . . . And then he asked me, "This is a nice thing you're doing. Is there something we can do for you?" I said, "Well this is going to sound a little strange, but I would love to have a picture of my kidney going to him . . . " He just looked at me and said, "Bring a camera!" So we got a disposable camera and I have pictures of my kidney in the metal bowl with him working on it and [the other] surgeon coming to get [the kidney]. (Hannah)

The organ donation and transplantation process involves people at every stage who take on crucial roles. For example, donors most frequently describe the transplant coordinator as an orienting figure in the process. Another central figure is the surgeon, whom people assume to be competent, albeit stereotypically impersonal. As surgeons show compassion toward donors and the sacrifices they experience through surgery and recovery, the donors feel cared for within the process. Conversely, recall Nancy's encounter where she felt the surgeon was dismissive toward her inquiries. Hannah's and Nancy's experiences underscore that just as health professionals can enable the progression of the process in a manner where donor sacrifices are managed, they can also amplify experiences of sacrifice.

The nephrectomy, the most obvious physical sacrifice by donors, occurs during a surgical procedure with donors fully anesthetized. Physical sacrifice is thus experienced primarily through the recovery process. Penelope describes a postsurgical recovery experience that is common among living organ donors:

> When I came out of surgery, I felt like I had been run over by ten trucks. One after the other! They just kept running me over. One after the other. I was a mess, just a mess. But deep down, I was

> happy because I could hear them telling me that my brother was fine . . . . You can't look at the moment of surgery. You have to look at the end result. (Penelope)

The transplant team provides an overview of all aspects of the process, including recovery. Recovery, both immediately after surgery and extending weeks afterward toward the goal of regaining full strength, is particularly challenging for donors given their high levels of health prior to donation. Recovery often requires that individuals refrain from several activities, including work, for anywhere from two to six weeks. The totality of sacrifices necessary by individuals to contribute to transplantation is most often deemed worthy, as exemplified by Penelope. The recovery portion of the donation process focuses primarily on clinical outcomes. While important, there are opportunities for organizations to support donors in the experiences of both physical sacrifice and psychic sacrifice as they strive to fully recover, in addition to pecuniary sacrifice through lost income and incurred costs.

For most donors, the process ends once they obtain medical clearance to resume their regular activities. For the organization, the process comes to a close approximately six weeks after surgery with the postsurgical lab work. Although the likelihood of negative outcomes is low for kidney donors, when they do occur, a timely and appropriately compassionate response by the organization is important. Recall Nancy, who traveled to another state to donate her organ. During postsurgery recovery, she experienced unexpected outcomes that were not explained or anticipated by the clinicians or found in her research:

> The transplant was successful. They had told me in advance that I'd probably stay in the hospital six days because I had so far to travel to go home . . . . Before I was discharged, I noticed that I had lost feeling in my one leg, in my one upper thigh of my left leg. I mentioned it to the doctor and they said, "It will disappear in six months." So, I literally marked on my calendar for the six months. And, the pain did not go away—it was intensifying. I wrote [the transplant center] and insisted that they examine me again. And, they confirmed that I had neurological damage in that leg. (Nancy)

Throughout the process, individuals are made aware of possible complications. While some complications from organ donation are resolved within the first year of surgery through additional clinical intervention (e.g., hernia repair) or lifestyle adjustments (e.g., fluid intake to address abnormal lab metrics), other complications may extend much longer (field notes). As with Nancy, Gregory experienced complications:

> It was in my exit interview, six days after surgery when I was released to come home, the same surgeon who operated on me said that it would probably be six to eight weeks before I would be out of the woods entirely . . . . At 8 weeks when I asked for a refill of pain medication, actually 8 weeks and 1 day, they said they had trouble with providing any pain medication after 8 weeks, and at 12 weeks when . . . the surgeon called me, I was surprised that he did, but a Saturday night he called me, and he said he had never had a patient who 12 weeks out was still in pain . . . . They never offered anything in terms of solution . . . . It felt to me like my internal organs were out of their normal position . . . . I asked if I could receive water therapy and [the surgeon] approved that. I asked if he would approve myofascial release work which I had learned about and I thought could help with what I was told was the scars were forming and the nerve tissue was probably entangled in the scars and myofascial release might work, and he denied that, he said no he wouldn't approve that. [He was] quite dismissive; as if I was saying, you know there's a witch doctor down the street. (Gregory)

These experiences are similar to those of some donors who continue to be challenged as a result of surgical complications that may require accommodation for an extended period of time. Thus, it is important that health care providers equip themselves to manage donor experiences that encompass a range of outcomes, including those of prolonged and unexpected sacrifice.

Although the process includes tests to assess mental and physical fitness and risks for donation, there are negative outcomes. As with Nancy and Gregory, medical complications that yield physical sacrifices are most often treated as exceptions to the process and may result in encounters with people who are not equipped to manage them within the context of the donation experience. Beyond physical complications, individuals may experience additional psychic sacrifices after donation. Consider Lizbeth, who donated to her brother with whom she had a standoffish relationship. Throughout the process, she describes feeling angst and frustration that she would have to donate to keep peace with her parents and brother. As a reluctant donor, she describes her experience:

> Donors, even donors who wanted to do this, feel like after, that "I was just a kidney walking in there with arms and legs attached." You'll find a lot of donors feel neglected and abandoned. . . . I called the doctor and now they don't want to talk to me. Now that I gave up the organ, now I'm not important to them. [It's] kind of like a girl who goes out with a guy and he said, "I love you! I love you!" and she sleeps with him. Then afterwards, he doesn't call her. Like that feeling of, "I gave something that was precious to me and now you don't even appreciate it." (Lizbeth)

Even years after the transplant and with great health, Lizbeth harbors resentment that neither the process nor the people within it did much to care for her emotionally and physically. While transplant organizations are in need of donors' organs, it is critical those donors are fully cared for in a manner that does not leave them feeling abandoned or exploited. It is thus imperative that organizations develop a supportive process staffed with compassionate people to mitigate sacrifices by individuals with less than ideal emotional or physical outcomes, a process that may well also enhance the product by heightening appeal to potential donors.

Nonprofits typically focus on messaging that promotes their product, which in the case of organ donation organizations translates as engendering a desire among potential donors to sacrifice an organ for a person in need. The experiences of

donors participating in the present study reflect the kinds of sacrifices that are common within the organ donor community and emphasize that such sacrifices need to be addressed by organ donor organizations. By pursuing mitigation strategies in the form of various marketing-mix elements, organizations can convey a cohesive value proposition in their quest to procure donors, one that speaks directly to the sacrifices that often accompany the donation of an organ.

Discussion

This study of living organ donation contributes to the literature by describing how elements of the marketing mix may be employed to attenuate donor experiences of sacrifice. Prior research has focused on how promotional messages may be employed to make individuals aware of donation opportunities and to overcome reluctance on the part of potential donors. While the aims of these promotions are crucial, we suggest how the marketing mix can be employed to mitigate concerns about the sacrifices often experienced by individuals as they advance through the donation process feeling valued as integral participants. As part of that strategy, we identify roles for the marketing mix—product, price, place, process, people, and promotion—that extend consideration beyond that of promotion. Thus, this research contributes an understanding of how organizations can more intentionally and systemically overcome potential donors' concerns and thereby increase the population of donors.

Managerial implications

Nonprofits contribute significant value to society together with support from the individuals who contribute to them. Securing donations is a primary challenge and focus for the delivery of these organizations' missions (Bendapudi, Singh, and Bendapudi 1996; Winterich, Mittal, and Aquino 2017). These findings are of particular interest to managers of nonprofit organizations who rely on individuals to offer contributions born of sacrifice that enable those organizations to deliver on their missions. Although these findings emerged from a particular type of donation, they are relevant to organizations that depend on contributions born of sacrifice, such as those seeking families to host foreign exchange students, those striving to facilitate the adoption of children who are difficult to place, those providing hospice support to individuals and their families during end-of-life transitions, or those offering compassionate care to individuals in crisis (e.g., sexual assault, domestic abuse, suicidal tendencies). These findings provide insight into how organizations can secure contributions, a necessary component of supply, to meet demand.

Prior research primarily has focused on how nonprofit organizations may employ promotional messaging to inspire contributions from individuals. We agree that promotion is certainly necessary, yet the present findings provide evidence suggesting that managers may be better served in meeting their missions by considering how to effectively employ the entirety of the marketing mix to attract individuals for available donation opportunities. We suggest that managers consider the composite of sacrifices required from individuals as they proceed through each phase of donation, and that managers employ the marketing mix to proactively and compassionately address the various types of sacrifice that emerge.

We identify actions for managers to employ the marketing mix—product, place, price, promotion, people, and process—in addressing each of the three types of sacrifice identified in the donation process (see Table 3). In addition to those specific actions identified, there are some general considerations for organizations. Product is reflected most clearly in a nonprofit organization's mission statement and manifests in the offering to which the donation supports. Place focuses on how disparate entities are integrated to support an individual's escalation of commitment from interested to committed as well as the delivery of the offering. Price is the component that conveys the costs incurred by donors to provide the contributions. Promotion is most often found in messages educating and persuading potential donors by conveying their importance to delivery of the offering. An organization's people are an important factor in delivering the entirety of the process and serve as a guide for donors throughout the process.

The process component reflects the steps required for individuals to transform from potential to actual donors, and it is the manifestation of the donation. The process we define is composed of three phases. In the deliberation phase of the process, individuals considering the opportunity are more involved in moving the process forward with some input from the organization. Within the decision phase, there is a balance of influence between individuals and organizations. As individuals move through to the donation phase, the balance of influence shifts toward the organization. Thus, an awareness of the process and perceptions of the organization to which individuals are contributing is also important. To an extent, donors are invited "backstage" (Goffman 1959) as they contribute to the creation of offerings for others. As such, it is imperative that organizations understand what they are asking of donors and how donors may experience sacrifice. Furthermore, it is important for donors to experience a degree of success, particularly when they are not able to readily observe the outcomes of their donations. Therefore, it is important that the processes to which donors contribute provide them with satisfaction that may be in some ways commensurate with the sacrifices they make to participate.

Importantly, process and people influence each phase of the donation experience and should be audited regularly to ensure that the interfaces between them and each phase, as well as the other marketing-mix components, are integrated. Furthermore, it may be helpful for managers to examine the milestones within a donation experience by assessing the extent to which those milestones are critical transition points for an individual to continue with the process of becoming a donor. Prior research has suggested that recognition may not be impactful to those who already contribute to nonprofit organizations (Winterich, Mittal, and Aquino 2013). However, it may be that

Table 3. Marketing and Organizational Considerations and Actions to Alleviate Sacrifices and Attract Organ Donors.

	Type of Sacrifice		
Marketing-Mix Element	**Psychic**	**Pecuniary**	**Physical**
A: Marketing Considerations and Messaging to Alleviate Sacrifices and Attract Organ Donors			
Product Offering created from donation	Delineate donor attributes (e.g., blood type, health metrics) required for the transplantation offering.	Identify potential costs associated with securing supply and ensure expedient reimbursement to donors.	Specify donor consequences of donation beyond transplant outcome and include adequate follow-up to assess progress toward intended outcomes.
Promotion Education about offering and persuasion to donate	Share impact of donation for recipients and community.	Communicate that participating as a donor is cash neutral, and proactively include reimbursement process.	Employ donor testimonials on the range of bodily impacts throughout the process and describe relevant support.
Place Environment for product sourcing, creation, and delivery	Provide a virtual tour of the process and the locations for each phase.	Facilitate access to direct billing for testing or immediate reimbursement for out of pocket expenses.	Assess organizational readiness prior to donor arrival to ensure designated space and adequate environment preparation.
Price Incurred costs to participate	Explain how transplant costs are covered by recipient insurance; explain how donor contribution enables the process.	Eliminate costs incurred for donation proactively; ancillary costs related to donation should be promptly reimbursed.	Provide materials to ensure donor comfort throughout donation and recovery free of charge.
Process Steps to source inputs for, create and deliver offering	Deliver training for donor communication to ensure the steps proceed in a respectful and compassionate manner before, during, and after the transplant.	Identify steps most likely to create costs (e.g., lab tests, transport to hospital, hotel stays while testing) and offer support (e.g., direct bill lab orders; prepaid hotel or transport) to donors.	Recognize the most likely physical and behavioral post-surgical challenges for donors; provide support to prepare and follow up with donors sufficiently.
People Individuals tasked with steps within the process	Provide necessary information and decision authority to process managers as they support donors within the process.	Ensure that participants who are facilitating the process have the capability to approve costs and facilitate reimbursements.	Equip participants to support donor physical and behavioral challenges with actionable, compassionate plans.
B: Organizational Considerations and Actions to Alleviate Experiences of Sacrifice			
Product Offering created from donation	Delineate impact of donation to organization mission and society.	Reduce cash outlays and reimburse quickly.	Connect challenge to impact of donation.
Promotion Education about offering and persuasion to donate	Communicate individual and cumulative benefits of donation.	Identify possible out of pocket expenses and note how they will be compensated.	Identify physical and behavioral requirements to participate and engage former donors to communicate "do-ability."
Place Environment for product sourcing, creation, and delivery	Create virtual tours and provide maps to facilitate navigation.	Identify and mitigate potential costs incurred by donors.	Provide comfortable workspace for donor contribution.
Price Incurred costs to participate	Explain how costs related to service creation and delivery are covered; connect donor contribution to delivery of client benefits.	Eliminate costs to participate as a donor; document the process for what may be reimbursed and how.	Provide all materials necessary to support donation.
Process Steps to source inputs for, create and deliver offering	Provide training to successfully support donors with respect and compassion.	Review steps to identify where costs may emerge and proactively manage them.	Recognize steps that may provide donors with physical difficulties and simplify.
People Individuals tasked with steps within the process	Ensure that participants have adequate compassion in their roles supporting donors to meet the organizational mission.	Provide decision-making authority to participants who support donors incurring costs and reimbursement processes.	Equip participants with tools and resources to provide donors with necessary support to donate successfully.

when the process to become a donor is more involved, it may be useful for organizations to provide motivation that inspires individuals to continue through the process.

The integration of each of the six marketing-mix elements is more likely to result in an environment in which individuals feel their donations are valued and respected. Each marketing-mix

element should be aligned to engender the desired response to the organization: that of converting an individual into a volunteer. A great deal of marketing research focuses on the types of messages or individual characteristics that are more likely to yield larger contributions for nonprofits. In the present research, we instead focus on how the marketing mix can be engaged to prepare individuals to engage in a donation opportunity. We find that marketing-mix elements mitigate sacrifice, which serves to engage individuals in the donation task and thereby increases the likelihood that they will continue. For organizations where donation may continue, the enactment of such sacrifices is likely to engender loyalty and continuity.

The implications of these findings are obviously important for organizations in need of tissue or organs to deliver on their mission. However, these findings are also relevant to organizations in need of donations generally. Consider the Center for the Homeless, a nonprofit serving those individuals without secure housing that is reliant on grants, fundraising, and donations. In particular, individuals donate clothing and food supplies, organize various life skills workshops for adults, and staff and equip a classroom for children. While there are various donors who contribute resources to support operations, the creation and maintenance of a Montessori classroom at this shelter is partially reliant on donor support. These donors contribute a significant amount of time, talent, and money annually to maintain a fully functioning classroom (e.g., books, computers, supplies) in addition to supporting training and funding for a full-time Montessori teacher.

The Center for the Homeless generates much promotion to increase awareness that there are homeless children in need of support, yet these findings suggest that it may be more effective for the center to leverage the composite of the marketing mix to attract donations to the Montessori classroom. Promotions may be helpful to clearly articulate the intention of providing quality education for homeless children at the center in such a manner that manages the psychic sacrifice individuals may experience as they contemplate the opportunity. However, more is needed to explain the role of this particular product, as it is nontraditional in the realm of a homeless shelter as well as a school. The product is education that serves as a bridge, aiding students in catching up until they are once again enrolled in a school. Thus, the product may involve specialized processes and require additional people beyond the teacher to provide adequate education. The place—that is, the Montessori classroom within the center, is organized to aid children to be treated like students who are able to learn. Thus, place includes features of a traditional classroom (e.g., textbooks, reading pods) while accommodating the necessarily transient and multiple-grade-level nature of its students. As with other types of donation opportunities, there may be incurred costs for donors (e.g., background check to work with minors, art project supplies). The marketing mix could be employed by the Montessori classroom to attract not only donations but also volunteers. More specifically, the center could more fully employ the marketing mix to attenuate psychic sacrifice (as individuals recognize they have limited capacity to assist homeless children), pecuniary sacrifices to participate, or the physical sacrifice that stems from being in an environment (e.g., smells, security, equipment) different from what they typically imagine encountering.

Organizations are not static, as evident in alterations to their operations, offerings, and positioning. As for-profit organizations alter their offerings, they often try to retain existing consumers and attract new ones, recognizing that each will invest differing psychic energies to consume the offering (Okada 2006). Similarly, nonprofit organizations could adjust their offerings to remain relevant to those they serve, thereby maintaining or growing their client base. For example, Habit for Humanity could upgrade its offerings by adapting the marketing mix through product attributes (e.g., new houses, disaster recovery, retail outlet), distribution (e.g., local and global builds), market messaging (e.g., model home challenges, Women Build Week), processes (e.g., one-time vs. long-term), or people (e.g., retail staff, policy advocates, board members). As they do so, it is important that they assess how those changes affect the degree of sacrifice required for existing and potential donors and operationalize the marketing mix to address those sacrifices. These examples underscore the importance of understanding how the marketing mix can be employed to mitigate sacrifice that emerges in the donation process as well as to enhance the overall donation experience. The deft employment of the marketing mix to extend the tenure of donors may also accrue other benefits to organizations such as confidence in operational projections, service stability, or reduction in expenditures to delivery services.

The extension of donor engagement may be viewed as a form of loyalty. Similar to brand loyalty, which has a positive impact on a firm's bottom line (Batra, Ahuvia, and Bagozzi 2012), it is likely that donor loyalty evident in their continued engagement with an organization also has a positive impact on an organization's performance. Consider blood donation, a relatively noninvasive procedure to obtain human tissue. Blood is donated to organizations that bank it for clinical usage. Some individuals consistently donate every eight weeks, often at the same facility. When individuals continue to donate to an organization, it is likely that they experience less psychic (e.g., contemplation), physical (e.g., blood draw, testing), and pecuniary (e.g., transport, time) sacrifice compared with their consideration and choice of new donation opportunities (e.g., child advocacy). Such continuity may also reduce the number of donors who switch their support to another organization or, worse yet, depart the donor marketplace. When organizations successfully communicate the value that donors help deliver to the marketplace and stimulate desire for individuals to donate and minimize sacrifices through the marketing mix, individuals are likely to engage as donors.

Opportunities for future research

The present study investigates living organ donors. While there are a growing number of living organ donors annually, the majority of transplants occur with organs offered by deceased donor families. Those families employ a different calculus

when considering donation of their loved one's organs (Fox and Swazey 2002; Healy 2006; Scott, Warren, and Ooi 2018; Sque, Payne, and Clark 2006). Where the present research focuses on those who make a choice to donate, further research is warranted to assess how the marketing mix can be employed to mitigate sacrifices for deceased donor families.

We focus on individual donors and their sacrifices. These individuals are embedded in social networks where those relationships likely influence the donation experience. The gift-giving literature provides insights into how the nature of social networks may shape the process and experience (Belk and Coon 1993; Bradford and Sherry 2013; Sherry 1983). An examination of donors' social networks and their influences may provide additional insights. Recall Lizbeth and Wilma. Lizbeth found her social network to be lacking in compassion and support, whereas Wilma found hers to be filled with care and consideration. Each recounted distinct experiences of the support they sought in the marketplace, which may be related to what was provided by their social network. Thus, there is an opportunity to understand how and to what extent social networks influence the donation experience providing donor-reliant organizations opportunities to understand and adequately prepare for donor support.

The current research theorizes sacrifice at the individual consumer level. Scholars in anthropology and theology theorize sacrifice at a community level in relation to social cohesion. Similar to the indigenous Chukchee people, who worked together to attain benefits for the collective (Mauss 1967), it may be that members of contemporary societies can be inspired to work together in support of beneficial societal outcomes. For example, several movements requiring individuals to employ sacrifices to attain societal benefits have gained momentum in recent years (e.g., #BlackLivesMatter, #MeToo, Get Out The Vote, #NeverAgain). Participation in those movements most likely involves psychic (e.g., contemplation of consequences of action and inaction), pecuniary (e.g., donations), and physical (e.g., protests) sacrifices. Therefore, it may be that sacrifices related to consumer movements may be viewed as enhancing participant commitment. Thus, it is important to explore how entities pursuing societal benefits (e.g., movements, nonprofits, civic organizations) can employ the marketing mix to attract and retain participants. It may be that for some movements, experiences of sacrifice are part of the personal benefit in addition to the societal benefits donors seek, and thus, organizations will have to understand to what extent and under what conditions they are to attenuate experiences of sacrifice.

Scholars have also suggested that organ donation may be viewed as a form of gift-giving to society (Bradford 2013; Strathern 2012; Titmuss 1997). Such gift-giving contributes much to the public good. Even as the marketing mix may be employed to generate even greater degrees of gift-giving, it must also be recognized that the same tools also may result in less-than-ideal outcomes. For example, the Susan G. Komen Foundation raises funds for breast cancer research and makes grants for breast cancer screening to organizations. The foundation effectively employed the marketing mix to inspire donations as individuals paid to participate in three-day races and secured additional contributions from others. In recent years, the organization has reduced grant-making capacity due to the decreased number of individuals willing to make donations. While monies were employed for the organization's mission, a significant amount was used for what donors perceived to be excessive non-mission-critical expenditures. Thus, it is imperative that scholars also consider factors that influence the relationship between marketing-mix elements, donor sacrifice, and perceived organizational effectiveness.

Conclusion

Consumer sacrifice allows donor-reliant organizations to attain their missions. We expand prior theories of sacrifice with an explanation of its three types and how they may be managed through the marketing mix. This explanation provides opportunities for managers to better understand how to more fully leverage the marketing mix to inspire individuals to partner with them by reducing experiences of sacrifice. Thus, those seeking more effective ways to procure donations for their organizations will benefit from understanding the nature of the relationship between sacrifice and the employment of the marketing mix to position their offerings.

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