Highlights

- This article uses the Polish migrant community as a case study for making new theoretical insights into the willingness to become an organ donor in a host country, using social capital theory.
- Elements of social capital were explored with participants such as social networks, civil engagement, trust, and reciprocity.
- Polish social networks were found to be small and the formation of networks to be influenced by English language skills.
- Participants were willing to donate organs to others inside and outside of their social networks in the United Kingdom and wanted to help a patient in need and influenced by the overall migrant experience in the United Kingdom and whether they felt a sense of belonging.
- It is concluded that an interplay of these social capital theories can reframe debates within organ donation such as reciprocity policies, the relevancy of altruism and the role of migration experiences, and networks in the willingness-to-donate organs posthumously in a host country.

The Potential Role of Social Capital in the Willingness to be a Deceased Organ Donor: A Case Study of UK Polish Migrants

C. Sharp* and G. Randhawa

Institute for Health Research, Putteridge Bury, University of Bedfordshire, Luton, United Kingdom

ABSTRACT

Background. In the United Kingdom, the demand for transplantable organs exceeds supply, leaving many patients on the active transplant waiting list with the majority on dialysis as the kidney is the most commonly transplanted organ. This is a marked issue across black, Asian, and minority ethnic communities. This article uses the Polish migrant community as a case study for making new theoretical insights into the willingness to become an organ donor in a host country using social capital theory.

Methods. There were 31 participants who took part in interviews and small group discussions. Grounded theory methodology was used as the study explored the relationships between deceased organ donation, religion, and Mauss's gift-exchange theory and the notion of social capital arose as an emergent theme from the study.

Results. Elements of social capital were explored with participants such as social networks, civil engagement, trust, and reciprocity. Polish social networks were found to be small and the formation of networks to be influenced by English language skills. Participants were willing to donate organs to others inside and outside of their social networks in the United Kingdom and wanted to help a patient in need and influenced by the overall migrant experience in the United Kingdom and whether they felt a sense of belonging. Overall, participants had mixed experiences and views about trust in the NHS.

Conclusions. Through a discussion of the results using a communitarian social capital, cognitive and structural social capital lens, and collective-action theory, it is concluded that an interplay of these social capital theories can reframe debates within organ donation such as reciprocity policies, the relevancy of altruism, and the role of migration experiences and networks in the willingness to donate organs posthumously in a host country.

IN THE United Kingdom, there is a huge shortage of organs from deceased donors for the use of transplantation; this is a significant public health issue. In 2013 to 2014, there were 3509 transplants from deceased organ donors and 7028 patients on the active transplant waiting list [1]. The deficit of organ donors leads to the use of costly treatment of dialysis because the majority of patients are waiting for a kidney. In the United Kingdom, ethnic minorities are 3 to 5 times more likely to require a kidney, but the lack of organs available to them from donors from similar ethnic backgrounds leads to extended waiting times compared with the white British population.

In the United Kingdom, the donation of an organ is framed as a form of altruism and gift-giving, largely influenced by the

work of Mauss [2] and Titmuss [3], but has failed to engage the public effectively to voluntarily donate organs. The notion of gift-giving based on Mauss's gift-exchange theory is based on the ideas of social exchange, in which items are exchanged to build social cohesiveness [4,5], social relationships and social networks [6–10], and social solidarity [11–15]. The limitations of applying Mauss's gift-exchange theory and the social psychological view of altruism to deceased organ donation led to the idea of social capital playing a potential role in deceased organ donation.

*Address correspondence to C. Sharp, Institute for Health Research, Putteridge Bury, University of Bedfordshire, Luton, UK. E-mail: chloe.sharp@beds.ac.uk

Social capital concepts were explored in the present study in relation to migrants' willingness to donate their organs posthumously in a host country. Migrants, in particular Polish migrants, make for a suitable case study for a number of reasons: this community comprises a relatively new and fast-growing community; uncovering how Polish migrants perceive organ donation will contribute toward the literature on ethnic minority views toward organ donation to provide an understanding of how relatively new migrants are building and using social networks and social capital, experiencing migration in the United Kingdom, and how these elements could influence the willingness to be an organ donor in a host country.

Social networks are considered a source of social capital. Bourdieu [16] and Bourdieu and Wacquant [17] argued that social capital existed within relationships with friends and members of groups and in turn influenced individual access to resources. Coleman [18,19] viewed social capital that existed within relationships within a family and membership to community groups such as church. Putnam [20] suggested that social capital existed within civic communities and was influenced by social networks in which there were norms of reciprocity and trust that could "improve the efficiency of society by facilitating coordinated actions and cooperation for mutual benefit." Putnam distinguishes between different types of social relationships: bonding and bridging. Bonding is the connection between people of similar backgrounds ("people like me") and bridging is connections made across a number of networks ("people not like me").

Social capital has been used in migration literature, largely the work of Coleman and Putnam [21] because they focus on communities and membership to associations and groups. Ryan et al [21] stated that for migrant social networks and social support, there are 3 assumptions about social capital that may not be readily applied. First, Coleman and Putnam focus on the stability of social relationships, but, for migrants, networks are fluid and change over time. Second, social networks are not deeply rooted in a specific geographical location such as a neighborhood but can expand trans-nationally. Third, Coleman and Putnam assume that high levels of social capital replace low levels of economic resources, but, for migrants, this may not be the case and social disadvantages may be maintained if social networks exist only within ethnic-specific networks. With Polish migrants as the focus of the present study, exploring social capital in relation to organ donation within this context will provide new theoretical insights.

Communitarian social capital is most frequently discussed in public health [22]; this form of social capital relies on dimensions of trust and civic participation and is attributed to Putnam's work of bonding and bridging principles [23]. Communitarianism favors self-reliance and lack of governmental involvement [24] and is supported by New Labour in the United Kingdom [25]. Communitarian social capital in public health advocates good community relations is good

for health; however, this idea has been criticized for being idealistic [26] and ignoring class, sex, and ethnicity [27].

Putnam's macro-social approach is suitable to the study because Putnam views social capital as a means to solving collective problems through cooperative action. Organ donation is couched in civic participation because it draws on the gift and altruism rhetoric, expecting individuals to civically engage through voluntary posthumous donation. Organ donation is a collective problem that only the public can solve through providing donors posthumously. In deceased organ donation, donating is a decision an individual makes about himself or herself to posthumously donate organs to a patient on the active transplant waiting list expressed through registration; if the individual dies, the family provides their consent for the donation to occur: all parties are anonymous, and it is organized and facilitated by the NHS. In the context of social capital, organ donors posthumously donate to strangers and cannot benefit from social capital because there is currently no form of reciprocity due to the anonymity of donor family and recipient and UK organ donation policy. Hence, the act of organ donation is a form of civic engagement, and having a further understanding of how a relatively new and growing migrant group feel about donating to benefit members of a host society could deepen the insight into the willingness of migrants to donate organs.

In general, there is a dearth of literature on social capital and its role in triggering organ, tissue, and blood donation, particularly for migrant populations. The literature available on living donation and blood donation shows that civic reciprocity and wanting to contribute toward the community could influence individuals' decisions to donate blood [28] and that blood donors perceived they were having an influence in their community and by donating blood they were affirming their affiliation to their community [29]. Putnam [20] suggested that for living donation, social capital could have an impact on opportunities to receive a living kidney donation. Dyer and McGuinness [30] argued that social capital has been criticized to drive the organ allocation process in living donation. If a person finds a donor within their social network, in turn benefitting from their social capital, this could influence allocation and in turn lead to inequalities. Giles [31] made a similar criticism of social capital in living donation in that without financial resources within social networks when trying to find a donor, there may be was no living donor.

Findings

This section will outline the findings to be discussed in the following section.

Polish Migrant Social Networks

Participants ($n = 10$) agreed that social networks had been loosely made before coming to Luton as friends or relatives may be living there already, making it more attractive as it was a "tried and tested" route of migration and location.

My cousin knows that person and it makes you feel safer, there's a stronger community over here already and I think that some people may feel a little bit, in case something happens, that they've got someone to turn to, because obviously they are in a foreign country, it does make them feel uncomfortable in many ways, for example, if their English is not very good (I1, Student, Post-2004).

Polish networks in the United Kingdom are small according to some participants (n = 10).

I'd say that, rather my group of friends is kept to a minimum, and closed, so meaning it is closed, and it is not very wide, eh I don't meet many new people, I happen to sporadically meet one new person a year- maybe more (I10, Warehouse worker, Post-2004).

Once in Luton and Dunstable, participants (n = 7) stated that non-English-speaking Polish migrants in low-skilled occupations had social networks comprising other Polish migrants, in which social capital benefited the individuals within the network.

They [the Polish migrants] manage to create something, like a little Poland let's say, but they help each other, let's say, share information, what to do, how to deal with problems...NHS or something, how to solve things, so they help each other, it appears that they have a good, strong community (I3, Student and Waiter, Post-2004).

It was possible to make connections with other Polish migrants through 2 Polish organizations: the Polish church and adjoining Polish club in Dunstable, according to 3 of the participants:

I think in Dunstable there is a Polish society club so they want to be unified, they want to spend time themselves as if, kind of like the Asian communities do, that it's just a big, closely knit community (I2, Student and Administrator, Post-2004).

Participants (n = 6) highlighted the challenges of being within a Polish migrant network:

[T]here are many Poles here, and I would tell you this, that in ninety nine per cent of them I see that jealousy, that envy, that if someone has it a bit better than them, that they will not speak to them; simple...we came to a house which we shared with 18 people, and we found work really fast, and they had, well they had work from some agencies...They envied us so much (I12, Student and Administrator, Post-2004).

For some participants (n = 6), having English language skills enabled them to network outside of the Polish community.

These [friends] are various types of people, they are Pakistani, they are English, they are Irish, and well it's just like I said...I have a very varied mix [of friends] from various groups (I9).

Social Capital and Organ Donation

Social Networks and the Willingness to Donate Organs in a Host Country. For many participants (n = 11), the willingness to donate organs was motivated by empathizing with the individual in need of an organ, to help another human being.

[W]ith organ donation, why shouldn't you give it to someone that you don't know or have any feeling, it's another human being, black, white or whatever, you know, that family is suffering, they need help (I19, Retired, Post-war).

Participants (n = 5) were willing to donate in the United Kingdom, were not willing to donate in any one country (n = 6), or would only donate to Polish people living in Poland (n = 3); participants were willing to donate organs within and outside of their social networks.

[C]ommunity for me is my family and friends, it may be 30 or 40 people that I am close to, the rest is people that I don't know, it wouldn't make a difference to me where in the world I was to be honest, realistically...I wouldn't donate an organ in order to help the community because I don't identify with the community. I would donate in order to help the person.

I never thought about this, that when I signing my donor card, that my organs are going to this hospital, because your accident can happen anywhere, so they stay there that they are transporting organs with a helicopter, you know to someone who is first in the queue...So, there's not people from Luton, but from whole UK I think, so (I17, Vet Technician, Post-2004).

Within the Polish migrant networks, 2 participants suggested that information had been passed on about registering as a donor in the United Kingdom or about organ donation in general from friends or relatives in the medical profession:

[W]hen I moved to England, I wanted to register straight away here...basically a friend told me what to do and how to register... on the Internet (Post-2004, Shop Assistant).

Civil Society and the Willingness to Donate Organs. Participants (n = 6) believed that Poles should participate in British society as if they were living in Poland.

[W]e're here now so we should do everything as if we were living in Poland or wherever else you're from, wherever you're from, you should be doing whatever you can to give, you know, to be a part of something because again, we need to help, we expect it but you should be at least able to consider helping in some kind of way and contributing to society (I1, Student, Post-2004).

However, participants (n = 6) said that they were more willing to help those that they knew, such as people they knew through university, work, or their children, rather than strangers.

I'd rather help a friend but probably not only (them), I'd probably help a third party as well (I10, Warehouse Worker, Post-2004).

When questioned about the notion of civic engagement and social responsibility toward UK society or one's community, there was a lack of consensus in the definition of "community." There were a variety of communities that one was part of when living in Luton and Dunstable, such as the church community, the neighborhood, the local geographical area, the workplace, and a group of parents from their child's school. Participants (n = 6) thought that organ donation was about helping an individual in need and not a contribution made to community or society.

I never thought I want to be society with the England community if I would give a donor like they would look at me like "oh yeah, she is really good because she give a donor"; no it's not, it's more like I don't care what they say if they communicate with me, if they talk to me, it's just human, it's a human for me (I15, Housewife, Post-2004).

It was highlighted by 2 participants that it is not possible to know patients in need as they will be outside of one's social network:

[I]n small communities and in small societies like in a village or something like that when everybody knows everybody then their sense of community may be stronger because all lived their life together...if you feel that you are part of the community and one of your neighbours is dying because they need a kidney, you might be willing to give it away, you know that how the neighbour of the family is suffering, because it's, you, because you see the pain and ok you can live with one, that may be willing to help more but in bigger communities, I think that it is difficult to have so much trust, you know and to be able to imagine what those people would feel to be interested in those people whatsoever you know (I5, Student and Bar Worker, Post-2004).

For many participants (n = 8), it was a sense of belonging and migration experience in the United Kingdom that motivated the willingness to donate organs. However, for some participants (n = 4), donation was not linked with a sense of belonging. The willingness to donate was seen to be a way of helping others or contributing to UK society by participants (n = 5).

I think [belonging] it can [link] because, I don't know, I just think that when there is a good atmosphere you feel more comfortable with things and, for example, if you feel secluded or negative or whatever from the start you're not going to want to participate in anything, you're going to want to go back home, you're not going to mix with society because you see no point but because, if it's welcoming and people are willing to listen to you and try new things, and you will hear people out and hear what they've got to say, um, yeah, I do think that, open society that is warm and welcoming and kind of influencing someone towards organ donation (I2, Student and Administrator, Post-2004).

The "gift of life" rhetoric for deceased organ donation came through the participants' responses as the organ was viewed by participants (n = 10) as a gift that was given voluntarily:

[O]rgan donation is of the highest rank [of helping others]' (I13, Warehouse Worker, Post-2004).

Trust in the NHS. The Poles were mixed in their views toward the NHS. Participants (n = 3) had negative experiences and did not trust the doctors' abilities, and others (n = 2) had positive experiences. Participants (n = 3) preferred to return to Poland to use the healthcare system there.

I don't tend to go there [the GPs] at all, I just do all my check-ups and things in Poland...it's easier for me to go to Poland during the holidays and actually do the check-ups and whatever I want, just pay and have it done and that's it, because here it's just really, really complicated to get an appointment (I7, Teacher, Post-2004).

Participants (n = 3) trusted NHS staff to save their life as an individual would not necessarily have a choice at the time. It was thought by participants (n = 2) that the experiences that people have with the NHS do not influence donation. However, some participants (n = 5) were more comfortable with Polish doctors because many had family members or friends who worked in healthcare and were aware of their training.

[A]s far as I know, something like organ donation doesn't, isn't based on the opinion of one doctor, it's like many, many doctors. I think that it's a proper board making a decision, which are totally scared of anything against law or something, so I think they may take some precautions, they make sure that you are going to die or that you are dead already, before they can take anything, I mean if you don't trust NHS about your health, who would you go to? (I3, Student and Waiter, Post-2004).

Two participants perceived there to be corruption and unfairness in organ allocation:

The level of corruption...maybe organ donation maybe organ transplant, if you know there is a list, but sometimes for some reason, some people can jump at least, you know, because they have money and they know, you know where the money should go and how to get on the top of the list (I4, Teaching Assistant, Post-1989).

DISCUSSION

Polish Community Social Networks and Social Capital

The present study found that Polish migrants contacted loose connections located in Luton and Dunstable before migrating to the area; English language skills can expand social networks outside of Polish social networks; and jealousy can challenge Polish migrant social relationships.

Schaefer et al [32] purported that there were different types of support that social networks and social relationships provide: emotional, informational, and instrumental. In the present study, when migrating to Luton and Dunstable, the participants sought informational and instrumental support through their “weak ties” (Granovetter [33]). The utilization of weak ties by migrants shows the function of bonding social capital in securing accommodation and work [34]. However, weak ties may be distanced at a later point in time, once the individual no longer requires the resources [35].

Once settled in Luton and Dunstable, English language skills were found to be a factor in whether people made friends with people like them (bonding) or people not like them (bridging), in this case Polish or non-Polish. English-speaking Polish migrants were more inclined to have bridging social capital through networks outside their ethnic group, based on similar interests such as being a student on the same course at university. For non-English-speaking Polish migrants, bonding social capital was more likely, and one participant referred to this group as “Little Poland” but may be socially disadvantaged, as Ryan et al [21] highlighted earlier.

The participants reported jealousy within the Polish community. White [36] suggested that most émigré communities have tensions within them and that it would be understandable if they were not cohesive. On the one hand, she explained that there is pressure for Polish migrants to integrate with the UK society, competition for jobs, and strain of the migration process. On the other hand, Poles want friends who are also Polish because it may be difficult to make friends with British people and there is a need to share information and support one another. White explained that newcomers from Poland may have limited social capital due to small social networks and solidarity comes from sharing the same ethnicity. The feelings of jealousy that Polish migrants feel may limit bonding social capital and possibly socially disadvantage individuals further as social networks would be smaller and fewer resources could be accessed.

Social Capital and the Willingness to Become a Deceased Organ Donor

Social capital was explored in the present study through Putnam’s lens; therefore social networks, community, and the notion of civic engagement to aid social cohesion within society were explored with the participants. There were 5 key findings from the present study: (1) participants were willing to donate organs within and outside of their communities to strangers in need of an organ living in the United Kingdom; (2) having a positive migration experience in the United Kingdom could motivate organ donation, perhaps to civically engage with society; (3) community, important concepts for Putnam and Coleman, was difficult to define by the participants, meaning that it was difficult to conceptualize what a person would be contributing to as an organ donor; (4) information about organ donation was

passed on through social networks; and (5) feelings of trust toward the NHS were mixed.

Second-Generation Collective-Action Theories: Trust and Reciprocity

Ostrom and Ahn [37] suggest there are second-generation collective-action theories that provide an analytical framework for social capital. They argue that social capital researchers take a collective-action approach to frame research problems. First-generation collective-action theories emphasize individuals as egoistic; second-generation collective-action theories are informed by behavioral and evolutionary game-theory models and assume that there are selfish and non-selfish individuals and take into account social motivation, implicated to trust in social capital theory [37]. In relation to organ donation, this links with cognitive social capital in feelings of social trust and Putnam’s trust in governmental institutions. Torsvik [38] believed that trust is not a type of social capital but an outcome and leads to collective action.

Ostrom [39] suggested a number of strategies for collective action based on reciprocity, viewed as a “personal social norm as well as a pattern of social exchange” [37]. Ostrom [39] purported the strategies including (1) an effort to identify who else is involved, (2) an assessment of the likelihood that others are conditional co-operators, (3) a decision to cooperate initially with others if others are trusted to be conditional co-operators, (4) a refusal to cooperate with those who do not reciprocate, and (5) punishment of those who betray trust. Trust is an integral part of reciprocity.

Hyppä [40] argued from a communitarian social capital standpoint that trust and reciprocity are products of structural dimensions of social capital and are characteristics of social capital. Communication (information) and social trust mediate social capital, and structural social capital through reciprocal trust strengthens social network. Sharp and Randhawa [41] outline Polish views toward reciprocity in deceased organ donation and found that organ donation was not viewed as a form of exchange in which reciprocity is expected because the organ should be given with altruistic intent but reciprocity would be acceptable. In the present study, trust in the NHS was explored because this would be the organization that would organize and facilitate organ donation. It was found that feelings of trust in the NHS were mixed; however, because the majority would donate in the United Kingdom, this would indicate that trust was not a deciding factor in the willingness to donate organs.

There is debate on the distinction between collective efficacy/collective action and communitarian social capital. Cagney and Wen [23] unpack these by defining social capital as social relationships and collective efficacy as the relationships being converted into collective action that benefits society and, in turn, links with Putnam’s definition of social capital. Sampson et al [42] believe that collective efficacy draws on the trust and solidarity concepts of social capital. Organ donation is a unique health behavior because it is an act that benefits another individual’s health but does

not influence the health of the donor in his or her lifetime. In the context of Polish migration, in which social relationships are fluid, mobility is likely due to economic motivation, length of stay is unknown, and it is interesting that Polish migrants view themselves as part of society and to take part in organ donation to help fellow human beings without being confined by social networks.

In a theoretical exploration of the relationship between social capital and organ donation, Sharp and Randhawa [43] draw on Uphoff's [44] framework of social capital and is commonly drawn on in health [40]. According to Uphoff, social capital is structural and cognitive; structural refers to how people behave such as participation in social networks and cognitive (cultural or psychological) social capital refers to how people feel, for example, perceived trust, reciprocity, and social support. These forms of social capital contribute toward Mutually Beneficial Collective Action (MBCA). The present study demonstrates that it is cognitive social capital that influences the willingness for migrants to become an organ donor as participants refer to how they feel living in the United Kingdom, for example, a feeling of belongingness in society spurred participants to want to donate their organs, a feeling of trust in the NHS, and a feeling of the imagined social support the individual will provide to patients in need of organs. This trend of wanting to help the individual and view the organ as a personal gift is in line with Boas's [45] notion of "restricted altruism" because individuals did not view the organ as a social good. These dimensions link with Putnam's concept of social capital of norms and reciprocity being coordinated for mutual benefit and collective action.

Role of Social Networks

Putnam's social capital theory lacks distinction between social capital sources and an individual's network [46,47]. In Coleman's theory, social capital is defined at individual level, but community ties are significant to the individual who benefits from these networks [18,48]. Coleman suggests that social capital is generated through reciprocity and norms, the consequences of having social capital in the form of information, and the social organization of sources and benefits that come from these. For Coleman [48], information provided through social networks is a basis for action. In the present study, the participants stated that their friends and relatives had given them information about becoming an organ donor in the United Kingdom, which, in turn, could lead them to register as an organ donation.

The present study shows that structural social capital through social networks on a micro-level do not influence the willingness to become an organ donor because participants were willing to donate within and outside of their social networks. However, Sharp and Randhawa [49] show that there are groups of people that a minority of Polish migrants would prefer not to donate to such as the need for body totality and perceived risk in being a deceased organ

donor. The donor and recipient are unknown to one another and the donor would no longer be living; therefore benefiting from social capital in this sense is not relevant. Social networks in relation to organ donation are instrumental in disseminating information because participants suggested that they learned about registering as an organ donor through their friends and relatives.

Bourdieu's social capital theory takes a micro-social approach and comes away from the communitarian concept in that individuals gain benefits for themselves and not the community as a whole [16,50,51]. Bourdieu's social capital theory combines cognitive and structural dimensions of social capital, and, in terms of the communitarian approach, both dimensions are important. However, Bourdieu's concept of habitus is relevant to the discussion as it explains the interaction the individual has with their social space within their social networks, the cognitive (psychological) aspect of social capital.

Bourdieu purported that each individual has a position in a social space that is defined by cultural, social, economic, and symbolic capital through social relations. Social networks formed the basis for social relations, which could produce or reproduce inequality. Within this social space, an individual develops "habitus" defined as "a structuring structure, which organizes practices and the perception of practices" [52]. The individual's habitus thereby will acknowledge, reinforce, and reproduce social forms of power, domination, and common views stemming from individual experiences. Bourdieu emphasized the role that social class places in influencing opportunities and social mobility. Participants viewed a connection between the feeling of belonging to UK society and organ donation.

The communitarian, collective view of social capital has been taken toward organ donation; however, Kawachi et al [53,54] suggest that in public health, social cohesion should be emphasized. Social cohesion and solidarity was explored with the participants; however, it was found that organ donation was considered to help others but did not strengthen social bonds within or outside of social networks. In the present study, it was too abstract for participants to imagine the solidarity they could feel in their lifetime because they had made the decision to donate organs after they died and instead imagined the patient who directly required the organ who he or she could be helping in the future.

The concept of community itself, a notion integral to Coleman and Putnam's theories, was problematic to define by the participants. The word "community" is contested [55] because it is a concept that is abstract and fluid, giving "our daily practices, our political differences and our understanding of ourselves significance." Popple [56] argued that there are different forms of community; these are based on locality or territory or commonality of interest or interest group, such as the black community or Jewish community. However, Mayo [57] explains that defining community based on locality existed in the past that had common values of solidarity, but that these communities may have been

imaginary. Mayo [57] argued that in the British context, traditional community is based on neighborliness and reciprocity among working-class communities. Communities of “interest” or “identity” are based on shared meanings [58] that are socially constructed [59]. Ryan et al [21] had argued that this is the limitation of applying social capital to the Polish migrant community because social networks and localities are fluid and changeable, whereas the individual is in the United Kingdom; therefore, this may contribute to the participants’ difficulty in defining what community meant to them in the United Kingdom.

Wider Context of Migration, Deceased Organ Donation, and Social Capital

Social capital synthesizes the problems of organ donation within society, culture, and institutions and is a useful way of re-framing wider organ donation problems within UK society such as lack of engagement with ethnic minority communities and debate on organ donation policy debates.

The negative side to social capital, in relation to organ donation, has been highlighted in previous research. Negative cognitive social capital could be a barrier to organ donation; for example, Morgan et al [60] found that black Caribbean migrants felt marginalized in the United Kingdom, and this discouraged participants from donating in the United Kingdom. Negative structural social capital embedded in the NHS [61] and social structures could explain inequalities [62] in accessing organ donation and transplantation across ethnical and racial groups that currently exist [63].

In Putnam’s social capital theory, the importance of social networks for communicating information, reciprocity, and trust are emphasized. In relation to organ donation, there is debate as to organ donation policy changes that could be based on reciprocity such as funeral expenses paid to donor families and priority on the active transplant waiting list; this in turn could facilitate collective action if it is incentivized, particularly if the strategies were tailored to both egoist and altruist individuals as second-generation collective action theories suggest. From a micro-social capital approach, these policy changes could engage the public as the individual will be ensuring their family were accessing resources by donating his or her organs, who will be contributing toward collective resources by consenting for their relative’s organ to be donated to help a person in need of an organ.

There is a need for further research in the exploration of the relationship between social capital and deceased organ donation across the indigenous and migration populations to examine the differences in the application of social capital theory. Research could examine the relationship through a Bourdieu lens for a different interpretation of the connections because the present study focused on Putnam’s communitarian view of social capital. The present study focused on individual willingness to donate organs. Further work on the family’s perspective and the role of social networks, trust, reciprocity, norms, and solidarity could inform future work.

There were limitations to the study: a small number of Polish migrants in one geographical area took part in the study; a grounded theory approach was taken, and, as the study developed, the interview guide developed as themes were explored, and not all participants answered all the questions posed and Putnam’s view of social capital informed the framework used in the study.

METHODS

Recruitment

Participants were recruited by the lead researcher (CS) by contacting the Polish Church in Dunstable and their affiliated Mother and Toddler Group, the Polish Saturday Morning School, the University of Bedfordshire, local workplaces, and community networks.

Sample

Thirty-one Polish migrants from Luton and Dunstable took part in the study (Table 1).

Data Collection

Data were collected between May and November 2011, using interviews and small-group interviews with 31 participants. Interviews were on average an hour and a half and took place at the University of Bedfordshire and the participants’ homes. For participants who were non-English speakers, an interpreter was used to conduct the interview with the lead researcher present with a “whispered translator” who gave a real-time account of the interview.

Table 1. Characteristics of Participants

	Post-War (n = 3)	Post-1989 (n = 1)	Post-2004 (n = 27)
Sex			
Male	2	0	7
Female	1	1	20
Age			
20–30 Years	0	0	24
31–40 Years	0	0	3
41–50 Years	0	1	0
51–60 Years	0	0	0
61–70 Years	1	0	0
70–80 Years	0	0	0
81–90 Years	1	0	0
91–100 Years	1	0	0
Length of stay in Luton/Dunstable			
0–1 Year	0	0	1
1–5 Years	0	0	20
6–10 Years	0	0	6
11–15 Years	0	0	0
16–20 Years	0	1	0
21+ Years	2	0	0
Born in Luton and Dunstable	1	0	0
Religion			
Catholic	3	1	20
No faith	0	0	6
Jehovah Witness	0	0	1

Data Analysis

A grounded theory approach was taken for the study because it was explorative and examined relationships between deceased organ donation, gift-exchange theory, and religion. The study was not aiming to test the concepts of social capital in their application to organ donation. The relationship between social capital and organ donation outlined in this paper is one of the emergent themes from the study.

Grounded theory is defined as “a systematic, inductive, and comparative approach for conducting inquiry for the purpose of constructing theory” [64], as an exploratory approach was taken for the overall study. Grounded theory coding process was applied: open coding, initial meaning given to the data, conduct constant comparison of old and newly generated data, codes were developed into main categories and sub-categories, and the core category was chosen and all categories were represented on a conceptual map. Codes were based on Putnam’s concept of social capital and emphasized networks, norms, and trust. All codes and categories were processed manually to organize the data and interpret the data.

Ethics

The study received ethical approval from the University of Bedfordshire Institute for Health Research Ethics Committee.

CONCLUSIONS

In a context of unstable and fluid social networks located in a host country, the Polish migrant community’s perception of the relationship between social capital and deceased organ donation led to new theoretical insights. There is growing research in the role of social networks and social capital in Polish migrant communities but limited literature on how this affects health behaviors such as the willingness to be an organ donor posthumously. In general, participants were positive about donating organs posthumously to individuals within and outside of their social networks and viewed organ donation as a form of civic engagement to reciprocate a positive migration experience but did not perceive donation to be strengthening social solidarity because it was a type of exchange between the individual’s family in the future and a recipient.

Social capital theory relevant to deceased organ donation is the intersection of cognitive and structural social capital, collective-action theory, and Putnam’s communitarian social capital and reframes aspects of organ donation in a macro-social context. Cognitive social capital such as feelings of belongingness to UK society and structural social capital such as the dissemination of information about organ donation through social networks were integral to deceased organ donation. Taking Putnam’s communitarian social capital and collective-action theory position enables a macro-social view to be taken to consider the norms of organ donation, currently to donate altruistically and the relevancy of this notion; reciprocity, because organ donation is not reciprocated and could be hindering organ donation through lack of incentivizing the public making a contribution toward collective action toward a collective problem and trust, the NHS organizes and facilitates organ donation and aims to engage the public and part of this engagement

strategy could be to build trust in healthcare professionals and the processes of organ donation.

REFERENCES

- [1] NHS Blood and Transplant. Activity Report 2013-2014. Available online: http://www.organdonation.nhs.uk/statistics/transplant_activity_report/ (accessed August 13, 2014).
- [2] Mauss M. The gift: the form and reason for exchange in archaic societies. Abingdon: Routledge; 2002.
- [3] Titmuss R. The gift relationship. London: Allen and Unwin; 1971.
- [4] Simmel G. Faithfulness and gratitude. In: Wolff K, editor. The sociology of Georg Simmel. New York: Free Press; 1950.
- [5] Ekeh PP. Social exchange theory: the two traditions. Cambridge, Mass: Harvard University Press; 1974.
- [6] Granovetter MS. The strength of weak ties: a network theory revisited: sociological theory. 1983;1:201–33.
- [7] Granovetter MS. The strength of weak ties. Am J Sociol 1973;78:1360–80.
- [8] Simmel G. The philosophy of money. London: Routledge; 1978.
- [9] Frow J. Time and commodity culture and gift and commodity essays in cultural theory and postmodernity. Oxford: Clarendon Press; 1997.
- [10] Cheal D. The gift economy. London/New York: Routledge; 1988.
- [11] Hobhouse LT. Morals in evolution: a study of comparative ethics. 1st ed. London: Chapman & Hall; 1906.
- [12] Thurnwald T. The psychology of acculturation. Am Anthropol 1932;34:557–69.
- [13] Ben-David OB. Organ donation and transplantation: body organs as an exchangeable socio-cultural resource. Westport, Conn: Praeger Publishers; 2005.
- [14] Komter AE. Solidarity and sacrifice: an analysis of contemporary solidarity. In: Stoneham LM, editor. Advances in sociology research: volume 2. New York: Nova Science Publishers; 2005.
- [15] Komter AE. Social solidarity and the gift. Cambridge: Cambridge University Press; 2006.
- [16] Bourdieu P. The logic of practice. Stanford: Stanford University Press; 1980.
- [17] Bourdieu P, Wacquant LJD. An invitation to reflexive sociology. Chicago/London: University of Chicago Press; 1992.
- [18] Coleman JS. Social capital in the creation of human capital. Am J Sociol 1988;94(Suppl):95–120.
- [19] Coleman JS. Foundations of social theory. Cambridge: Harvard University Press; 1990.
- [20] Putnam RD, Leonardi R, Nanetti RY. Making democracy work: civic tradition in modern Italy. Princeton, NJ: Princeton University Press; 1993.
- [21] Ryan L, Sales R, Tilki M, Siara B. Social networks, social support and social capital: the experience of recent polish migrants in London. Sociology 2008;42:672.
- [22] Moore S, Shiell A, Hawe P, Haines VA. The privileging of communitarian ideas: citation practices and the translation of social capital into public health research. Am J Public Health 2005;95:1330–7.
- [23] Cagney KA, Wen M. Social capital and aging-related outcomes. In: Kawachi I, Subramanian SV, Kim D, editors. Social capital and health. New York: Springer; 2007.
- [24] Etzioni A, George RP. Virtue and the state: a dialogue between a communitarian and a social conservative. Respons Commun 1999;9:54–6.
- [25] Muntaner C, Lynch J, Smith G. Social capital and the third way. In: Green J, Labonte R, editors. Critical perspectives in public health. Abingdon: Routledge; 2009.
- [26] Lynch JW, Kaplan GA. Wither studies on the socio-economic foundations of public health? Am J Public Health 1997;87:1409–11.

- [27] Muntaner C, Nieto J, O'Campo P. Additional clarification re: on race, social class and epidemiologic research. *Am J Epidemiol* 1997;146:607–8.
- [28] Smith A, Matthews R, Fiddler J. Blood donation and community: exploring the influence of social capital. *Int J Social Inquiry* 2011;4:45–63.
- [29] Alessandrini M, Carr A, Coghlan P. Building social capital through blood donation: the social futures project. *ISBT Sci Series* 2007;2:46–52.
- [30] Dyer P, McGuinness S. The organ allocation algorithm. In: Farrell AM, Price D, Quigley M, editors. *Organ shortage: ethics law and pragmatism*. Cambridge: Cambridge University Press; 2011.
- [31] Giles S. An antidote to the emerging two tier organ donation policy in Canada: the Public Cadaveric Organ Donation Program. *J Med Ethics* 2005;31:188–91.
- [32] Oakley A. *Social support and motherhood*. Oxford: Blackwell; 1992.
- [33] Granovetter M. A theoretical agenda for economic sociology. In: Guillen MF, Collins R, England P, Meyer M, editors. *New directions in economic sociology*. New York: Russell Sage Foundation; 2002.
- [34] Moriarty E. From migration to mobility: Polish nationals in the Irish labour market, European Sociological Association. Geneva: University of Geneva; September 7–10, 2011.
- [35] Bielewska A. The settlement patterns of Polish immigrants in Manchester in the context of move from modern to post-modern understanding of place. *Geographia Polonica* 2011;84:19–32.
- [36] White A. *Polish families and migration since EU accession*. Bristol: Policy Press; 2011.
- [37] Ostrom E, Ahn TK. The meaning of social capital and its link to collective action. In: Svendsen GT, Svendsen GL, editors. *Handbook on social capital*. Northampton, Mass: Edward Elgar; 2008.
- [38] Torsvik G. Social capital and economic development. *Rational Soc* 2000;12:451–76.
- [39] Ostrom E. A behavioral approach to the rational choice theory of collective action. *Am Polit Sci Rev* 1998;92:1–22.
- [40] Hyypä MT. Healthy ties: social capital, population health and survival. London: Springer; 2010.
- [41] Sharp C, Randhawa G. Organ donation as an 'altruistic gift': incentives and reciprocity in deceased organ donation from a UK Polish migrant perspective. *Ann Transplant* 2014;9:23–31.
- [42] Sampson RJ, Raudenbush SW, Earls F. Neighbourhoods and violent crime: a multilevel study of collective efficacy. *Science* 1997;277:918–24.
- [43] Sharp C, Randhawa G. Social capital and deceased organ donation. In: Randhawa G, editor. *Organ donation and transplantation: public policy and clinical perspectives*. InTech: Open Access; 2012.
- [44] Uphoff N. Understanding social capital: learning from the analysis and experience of participation. In: Dasgupta P, Serageldin I, editors. *Social capital: a multifaceted perspective*. Washington, DC: World Bank; 2000.
- [45] Boas H. Where do human organs come from? Trends of generalised and restricted altruism in organ donations. *Soc Sci Med* 2011;73:1378–85.
- [46] Portes A. Social capital: its origins and applications in modern sociology. *Ann Rev Sociol* 1998;24:1–24.
- [47] Portes A. The two meanings of social capital. *Sociol Forum* 2000;15:1–12.
- [48] Coleman JS. Social capital in the creation of human capital. In: Disgupta P, Serageldin I, editors. *Social capital: a multifaceted perspective*. Washington, DC: The World Bank; 2000.
- [49] Sharp C, Randhawa G. UK Polish migrant attitudes toward deceased organ donation: findings from a pilot study. *J Immigr Minor Health* 2015;17:1157–62.
- [50] Bourdieu P. *Distinction: a social critique of the judgement of taste*. Boston, Mass: Harvard University Press; 1979.
- [51] Bourdieu P. The forms of capital. In: Richardson J, editor. *Handbook of theory and research for the sociology of education*. New York: Greenwood; 1986.
- [52] Bourdieu P. Translated by Nice R. *Distinction*. Boston, Mass: Harvard University Press; 1984.
- [53] Kawachi I, Kennedy BP. Health and social cohesion: why care about income inequality? *BMJ* 1997;314:1037–40.
- [54] Kawachi I, Subramanian SV, Kim D. *Social capital and health*. London: Springer; 2008.
- [55] Howarth C. Towards a social psychology of community: a social representations perspective. *J Theory Social Behav* 2001;30:223–38.
- [56] Popple K. *Analysing community work*. McGraw-Hill; 1995.
- [57] Mayo M. *Cultures, communities, identities: cultural strategies for participation and empowerment*. Basingstoke: MacMillan; 2000.
- [58] Lash S. Reflexivity and its doubles: structure, aesthetics, community. In: Beck U, Giddens A, Lash S, editors. *Reflexive modernisation: politics, tradition and aesthetics in the modern social order*. Stanford, Calif: Stanford University Press; 1994.
- [59] Castells M. *The power of identity: the information age: economy, society and culture*. 2nd ed. Oxford: Blackwell; 1997.
- [60] Morgan M, Adams OP, Seed PT, Jones R. Ethnicity and attitudes to deceased kidney donation: a survey in Barbados and comparison with Black Caribbean people in the UK. *BMC Public Health* 2010;10:266.
- [61] Healy K. Altruism as an organisational problem: the case of organ procurement. *Am Sociol Rev* 2004;69:387–404.
- [62] Uphoff EP, Pickett KE, Cabieses B, et al. A systematic review of the relationships between social capital and socioeconomic inequalities in health: a contribution to understanding the psychosocial pathway of health inequalities. *Int J Equity Health* 2013;12:54.
- [63] Randhawa G. Death and organ donation: meeting the needs of multiethnic and multiethnic populations. *Br J Anaesth* 2012;108(Suppl):i88–91.
- [64] Bryant A, Charmaz K. *The Sage handbook of grounded theory*. London: Sage Publications; 2007.