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Requesting life through the voice of a mediator: A psychosocial study of the effect of mediation in requesting donations between relatives of patients with liver and kidney failure

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Abstract

Background:
Liver and kidney failure impose profound physical, psychological, and social burdens on patients and their families. The process of soliciting organ donations from relatives often triggers emotional distress, communication barriers, and relationship tension. Mediation—facilitated by a neutral third party—has been proposed as a psychosocial tool to ease this process and foster informed, empathetic decision-making.

Objective:
This study examined the psychosocial impacts of mediation in facilitating organ donation requests among relatives of patients with liver or kidney failure, focusing on communication dynamics, emotional challenges, and acceptance of the mediator's role.

Methodology:
A **quantitative descriptive research design** was employed. The study population included patients with organ failure, their relatives, healthcare practitioners, and administrative staff involved in transplant processes. A total of **1,027 participants** were recruited from hospital transplant units, patient support groups, and professional health associations. Data were collected using a structured questionnaire covering demographic variables and 25 Likert-scale items assessing emotional responses, communication barriers, and perceptions of mediation. Data were analyzed using **SPSS** for descriptive statistics and interpretation of mean scores.

Results:
Findings indicated moderate difficulty in directly requesting organ donations from relatives (M = 2.33), with notable fears of relationship tension (M = 2.60) and feelings of embarrassment (M = 2.34) or guilt (M = 2.50). Avoidance behaviors due to fear of rejection were common (M = 2.26). Participants expressed generally positive views about mediation, agreeing that it could make the process easier (M = 2.14), enhance comfort in discussions (M = 2.01), and reduce embarrassment (M = 1.95). Mediation was also perceived to increase relatives' willingness to consider donation (M = 1.85) and create a fairer, calmer discussion atmosphere (M = 2.03). Strong endorsement was given to involving social workers or psychologists (M = 1.56), providing awareness programs (M = 1.47), ensuring psychological preparation (M = 1.28), and making mediation an available option for all patients (M = 1.33).

Conclusion:
The study highlights significant emotional and communicative barriers in requesting organ donations from relatives. Mediation emerges as a promising strategy to mitigate these challenges, improve family dialogue, and enhance acceptance of donation requests. Integrating mediation into transplant communication protocols, alongside psychological support and structured awareness initiatives, may promote more compassionate and effective donor solicitation processes.

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الملخص

الخلفية:

يشكل فشل الكبد والكلى عبئاً جسدياً ونفسياً واجتماعياً كبيراً على المرضى وأسرهم. غالباً ما يثير طلب التبرع بالأعضاء من الأقارب ضغوطاً نفسية وحواجز في التواصل وتوتراً في العلاقات الأسرية. ويُعد التدخل الوسيط، الذي يقوم به طرف ثالث محايد، أحد الأدوات النفسية-الاجتماعية المقترحة لتيسير هذه العملية وتعزيز اتخاذ قرارات مبنية على التعاطف والمعرفة.

الهدف:

هدفت هذه الدراسة إلى فحص الأثر النفسي-الاجتماعي للوساطة في تسهيل طلبات التبرع بالأعضاء من أقارب مرضى فشل الكبد أو الكلى، مع التركيز على ديناميكيات التواصل، والتحديات العاطفية، ومدى تقبل دور الوسيط.

المنهجية:

تم استخدام تصميم بحثي كمي وصفي. شملت عينة الدراسة مرضى الفشل العضوي، وأقاربهم، والممارسين الصحيين، والموظفين الإداريين المشاركين في عمليات الزرع. بلغ عدد المشاركين 1,027 شخصاً تم تجنيدهم من وحدات زراعة الأعضاء في المستشفيات، ومجموعات دعم المرضى، والجمعيات المهنية الصحية. جُمعت البيانات باستخدام استبيان مُهيكل تضمن بيانات ديموغرافية و25 عبارة على مقياس ليكرت لقياس الاستجابات العاطفية، وحواجز التواصل، والتصورات حول الوساطة. تم تحليل البيانات باستخدام برنامج SPSS لاستخراج الإحصاءات الوصفية وتفسير المتوسطات الحسابية.

النتائج:

أظهرت النتائج وجود صعوبة متوسطة في طلب التبرع بالأعضاء مباشرة من الأقارب (المتوسط = 2.33)، مع بروز مخاوف من حدوث توتر في العلاقات الأسرية (المتوسط = 2.60) وشعور بالإحراج (المتوسط = 2.34) أو الذنب (المتوسط = 2.50). كما كانت سلوكيات التجنب بسبب الخوف من الرفض شائعة (المتوسط = 2.26). أبدى المشاركون آراءً إيجابية عامة تجاه الوساطة، حيث أقروا بأنها قد تسهّل العملية (المتوسط = 2.14)، وتزيد من الراحة في النقاش (المتوسط = 2.01)، وتقلل من الإحراج (المتوسط = 1.95). كما اعتبروا أن الوساطة قد تزيد من استعداد الأقارب للتبرع (المتوسط = 1.85) وتوفر جواً أكثر عدلاً وهدوءاً للنقاش (المتوسط = 2.03). وأوصى المشاركون بقوة بضرورة إشراك الأخصائيين الاجتماعيين أو النفسيين (المتوسط = 1.56)، وتقديم برامج توعوية (المتوسط = 1.47)، وضمان الإعداد النفسي المسبق (المتوسط = 1.28)، وتوفير خيار الوساطة لجميع المرضى (المتوسط = 1.33).

الخلاصة:

تكشف الدراسة عن وجود حواجز نفسية وتواصلية مهمة عند طلب التبرع بالأعضاء من الأقارب. وتبرز الوساطة كاستراتيجية واعدة للتغلب على هذه التحديات، وتحسين الحوار الأسري، وزيادة تقبل طلبات التبرع. إن دمج الوساطة ضمن بروتوكولات التواصل في عمليات الزرع، إلى جانب الدعم النفسي والمبادرات التوعوية المنظمة، قد يسهم في تعزيز عملية طلب التبرع بشكل أكثر تعاطفاً وفعالية.

Introduction:

Organ donation is still one of the most important and life-saving medical procedures available today, yet it still has a lot of problems with availability and access. Patients with end-stage liver or kidney failure frequently depend on prompt transplants as their sole possible means of survival. Even while surgical methods, post-transplant care, and immunosuppressive medicine have all gotten better, there is still a big difference between the number of people who need organs and the number of people who can give them. This lack is especially clear when donations depend on living relatives, since emotions, culture, and relationships can all have a big impact on decisions (De Pasquale et al.,2020).

One of the most delicate parts of living organ donation is asking for the donation itself, especially when it happens in a family. The process of asking a family member to think about doing something that could change their life and put them at risk requires more than just medical eligibility. It is also profoundly rooted in cultural, psychological, and relational factors. The fear of damaging familial ties, feelings of guilt or shame, worries about apparent compulsion, and cultural views about bodily integrity all affect how likely someone is to ask for help and how likely they are to give it. These barriers become more pronounced when the patient or their immediate family is responsible for making the request, resulting in increased emotional strain on both parties (Rotella et al.,2019).

Because of these difficulties, the idea of mediation in organ donation has become more popular as a way to help people talk to and understand each other. In this case, mediation means that a neutral, trusted third party, like a skilled healthcare professional, counsellor, or social worker, helps start and guide the conversation between the patient's family and possible donors. Mediators may make the room safer for both the requester and the possible donor by taking a balanced approach that puts empathy, respect, and clarity first. This method not only helps clear up misunderstandings and ease emotional stress, but it can also make it more likely that a decision will be made with care and thought (Tarabeih et al.,2020).

The psychosocial ramifications of mediated contribution requests are significant. Prior research in health communication indicates that mediation can alleviate interpersonal tension, confront unexpressed anxieties, and deliver precise medical information with emotional sensitivity. Also, mediation could assist change the way the request for a donation is framed, turning it from a burdensome appeal into an informed invitation based on shared values and family responsibilities. This change in framing can be quite important in cultures or societies where family honour, giving and receiving, and making decisions as a group are all important factors (Bülbüloğlu et al.,2021)

When someone has liver or renal failure, these dynamics become much more important. Liver and kidney transplants generally rely largely on living donors, especially in countries where the number of deceased donors is minimal. This is different from some other types of organ donation that might use contributions from people who have died. This means that the social, psychological, and relational factors that affect requests for living donations have a direct and immediate effect on how long a patient lives. The stakes are enormous, both medically and emotionally, because the process can change how families interact with each other in ways that linger. A successful contribution can bring families closer together and make them feel like they've all won. On the other hand, a refusal, especially if not handled well, can leave people feeling angry, guilty, or alone (Quick et al.,2024).

So, the mediator's job is not just to pass on facts; they also have to be able to handle this emotionally charged situation with care and competence. This means checking to see if both the patient and the possible donor are mentally ready, making sure that everyone knows the risks and advantages, and encouraging open and honest conversation. Mediation is also important because it gives both the patient's needs and the possible donor's freedom an organised way to be heard. This helps keep relationships strong no matter what happens with the request.

From a psychosocial standpoint, the mediator functions as a conduit between medical necessity and human feeling. Having a professional intermediary there can help everyone feel less pressure, acknowledge their feelings, and make decisions that are both educated and free. Mediation can also assist clear up any false information or unrealistic expectations that may come up when someone is donating an organ, especially if the family doesn't know much about medicine.

Even while mediated contribution requests seem like a good idea, there isn't much real-world research on them, especially in certain cultural and healthcare circumstances. To make effective interventions, we need to know how mediation influences the results of donations, family ties, and the mental health of both patients and potential donors. This is especially important in places where not many people donate organs and where cultural norms may make it harder to talk openly about living organ donation (Rotella et al.,2019).

This study seeks to investigate the psychosocial impacts of mediation in the context of soliciting donations among relatives of patients with liver and renal failure. The study aims to enhance comprehension of how structured, sympathetic communication might affect significant health decisions by analysing both the subjective experiences of the participants and the objective results of mediation. The results could help shape healthcare policy, improve the training of mediators, and make organ donation practices better by adding psychosocial factors to the medical process. The ultimate objective is to furnish evidence that advocates for more empathetic, efficient, and culturally attuned methodologies regarding one of the most sensitive appeals an individual can make—the solicitation for the gift of life.

Research Problem

Organ transplantation represents a critical and often life-saving intervention for patients with end-stage liver and kidney failure. However, the shortage of available organs remains a persistent global challenge, particularly when the potential donors are family members who may experience complex psychological, emotional, and social pressures. While direct requests for donation can sometimes result in resistance, tension, or feelings of guilt among relatives, the use of a mediator—someone who can facilitate communication and present the request in a supportive and non-confrontational manner—has emerged as a potentially effective approach.

Despite its promising implications, there is limited empirical evidence examining the psychosocial dynamics and effectiveness of mediation in organ donation requests within familial contexts. Most existing studies focus on medical, legal, or logistical aspects of organ donation, with insufficient attention to the interpersonal and emotional factors that influence decision-making. This creates a significant research gap, particularly in understanding how mediation can reduce relational strain, address emotional barriers, and improve willingness to donate among relatives.

Given the urgent need to enhance organ donation rates while preserving family relationships, it becomes essential to investigate whether mediation can act as a bridge between patients' needs and relatives' decision-making processes. By exploring the psychosocial impact of this approach, the present study seeks to address this gap and contribute to strategies that not only save lives but also maintain emotional well-being within families facing these critical decisions.

Significance of the Study

This research is of considerable importance in both scholarly and practical contexts, since it examines a delicate and frequently overlooked aspect of organ donation—the function of mediation in facilitating requests among relatives of individuals with liver and kidney failure. From a psychological standpoint, the solicitation of organ donations among family members transcends simply medical or logistical considerations; it is profoundly rooted in emotional, cultural, and relational frameworks. Many people who might want to help may not be able to because they can't talk to each other, they feel uncomfortable, or they are afraid of hurting their family bonds. Mediation provides a disciplined, compassionate, and impartial framework that helps reconcile these disparities, fostering open communication and reciprocal comprehension.

This research adds to the body of academic work on organ donation by looking at how mediated communication works in families. This is something that hasn't been studied enough, especially in Middle Eastern and Arab cultures. The study enhances current understanding of how mediation might positively affect interpersonal dynamics, family cohesion, and emotional readiness to boost donation rates.

In practical terms, the results of this study could help healthcare staff, legislators, and social workers understand how useful it is to have trained mediators involved in the organ donation process. Hospitals and transplant programs might make mediation a formal part of the process. This would help people feel less emotionally resistant, make communication easier, and provide a more supportive environment for making decisions. In the end, this can lead to more organs being available, higher survival rates for patients, and a more caring approach to healthcare that respects both the donor and recipient families.

Theoretical Framework:

1. Psychological and Social Consequences of Liver and Kidney Failure

Liver and kidney failure are among the most serious long-term health problems since they cause organs to work less and less over time, and this often can't be fixed. These diseases are very hard on individuals' physical health, mental health, and social lives. In advanced stages, medical measures like dialysis, rigorous food restrictions, and frequent hospital visits become part of the patient's everyday existence, often forcing substantial changes to their way of life (Amatya et al.,2021). For a lot of patients, organ transplantation is the only long-term therapy that works, but it comes with a lot of hazards, complicated medical procedures, and the difficulty of finding a compatible donor. In most situations, this donor is a family member because being genetically compatible makes the surgery more likely to work and less likely to cause organ rejection (De Pasquale et al.,2020).

But the path to transplantation is full with psychological and social problems. Patients may experience chronic anxiety regarding their prognosis, fear of death, and a sense of helplessness when confronted with a life-threatening ailment (Rotella et al.,2019). Existential concerns—questions about the meaning of life, their place in the family, and the burden they may put on loved ones—can make these feelings even worse. Family members also feel emotional stress as they deal with the patient's pain, worry about the future, and the moral issues surrounding organ donation (Nagel et al.,2020).

These diseases can break up families socially. The ongoing need for medical care can put a strain on relationships, cause arguments about who should take care of the sick person, and make tensions that were already there worse. When you need to ask a close relative for an organ donation, the situation might get even more tense (Bülbüloğlu et al.,2021). Such a request may elicit feelings of doubt, shame, or hostility, especially if family members perceive pressure to make a consequential decision. In this setting, a psychosocial viewpoint is essential for comprehending the impact of emotional, relational, and cultural aspects on familial decision-making processes (Tarabeih et al.,2020).

2. The Function and Definition of Mediation in Organ Donation Appeals

When it comes to organ donation between family members, mediation is when a neutral third person, like a healthcare expert, social worker, or trained counsellor, helps the patient's family members talk to each other and make decisions. The mediator's job is to fill in emotional and informational gaps, ease tension, and make sure that the talk is respectful and culturally appropriate (Kong,2022).

Mediation in this context is based on a few key ideas: neutrality (making sure the mediator doesn't favour either the patient or the potential donor), confidentiality (keeping everyone's privacy safe), empathic listening (actively acknowledging and validating emotions), and cultural competence (being aware of the family's cultural norms, values, and religious beliefs)(Quick et al.,2024). Mediation seeks to convert a potentially adversarial or emotionally charged request into a structured, objective dialogue by sticking to these principles (Miller et al.,2022).

Mediation gives a secure, controlled place for discourse instead of putting family members in the unpleasant position of directly asking each other for a life-saving organ, which is often full with shame, scepticism, or resentment (Sallis et al.,2018). In this case, the request can be made in medical and ethical terms, which helps potential donors realise how urgent the issue is, what might happen, and the social benefit of giving. This method also encourages informed consent, which means that any choice made is free from pressure, well thought out, and voluntary (Wang & Zhao,2018).

3. Psychosocial mechanisms in requests based on mediation

Mediation brings into play a number of interconnected psychosocial mechanisms that can have a big effect on how families respond to organ donation requests (Iqbal et al.,2020).

3.1. Reducing Stress and Ambiguity

Medical emergencies that require immediate organ transplants can put a lot of emotional stress on patients and their families. This tension might make it hard for people to think clearly about the pros and cons of a situation. Families may also feel uncertain because they don't have all the medical information they need, they don't understand it, they have different ideas about the patient's prognosis, or they don't know what to expect from the donation procedure (Karimi, et al.,2023).

A good mediator may help people feel less stressed and uncertain by giving them clear, accurate medical information, explaining possible outcomes, and giving them emotional support. The mediator sets up the debate and leads it in a way that encourages positive, solution-focused conversation. This makes it easier to make decisions. The Integrated Psychosocial Model of Relatives' Decision About Deceased Organ Donation (IMROD) finds ambiguity and stress as significant cognitive-emotional impediments to consent, indicating that treatments designed to mitigate these factors may enhance the probability of favourable decisions. IMROD was created for deceased donation, but its ideas can also be used for living-related donation situations (Huyghebaert et al.,2018).

3.2. Enhancing Family-Centered, Compassionate Communication

Studies repeatedly demonstrate that the method of communication about organ donation requests significantly influences family consent. Requests that are made with warmth, empathy, and cultural sensitivity are much more likely to get positive responses than those that are made in a cold, impersonal way or that focus too much on medical or technical aspects. In situations where people give their organs to each other, the quality of communication between people is very important, especially when emotions are running high (Ahmed et al.,2021).

A mediator who is a caring facilitator can show how to communicate well by balancing facts with feelings. This means recognising how potential donors feel, admitting how hard the decision is, and encouraging a collaborative rather than confrontational tone. This method is in line with the concepts of family-centered care, which put the needs, values, and preferences of all family members first (Basit,2021).

3.3. Communication that isn't spoken and that persuades

There is more to communication than just talking. Things like body language, tone of voice, eye contact, and tempo can change how people understand what you say. Research shows that people who ask for something in a spontaneous, passionate, and sincere way are more likely to get it than people who seem overly rehearsed or stiff (Stockton et al.,2019).

Using open body language, pleasant facial expressions, and a calm voice in mediation can show that you care and help create trust. In this case, ethical persuasion doesn't imply playing with people's feelings. Instead, it means framing the decision in a way that shows how important it is to people and how it might help others, while also making sure that potential donors feel respected and free to make their own choices (Paul Vincent et al.,2023).

3.4. Dealing with moral duties and giving back

People commonly call organ donation the "gift of life," which is a metaphor that can have complicated moral meanings, even though it is meant to be positive. Some people call this "the tyranny of the gift," which means that the person who receives the gift may always feel like they owe the donor something. In family situations, this might show itself as shame, obligation, or even changes in how people relate to each other after a donation. Potential donors may experience apprehensions of coercion, familial expectations, or the enduring effects on their health (Men et al.,2020).

Mediation gives people a chance to talk about these moral and relationship issues in a safe space. Mediators can help both donors and recipients deal with sentiments of reciprocity by reframing the giving as a choice, selfless act instead of a transactional duty. This new way of looking at things can help people feel better and lower the chances of feeling bad about giving or having family problems after giving (Ahmad et al.,2018).

Research Methodology

Research Design

This study utilised a quantitative descriptive research methodology to investigate the psychosocial impacts of mediation in soliciting organ donations from families of patients with liver and renal failure. The design was selected to systematically measure participants' views, feelings, and attitudes about donation requests, emphasising the function of mediators in enhancing communication within familial situations. The quantitative method facilitated statistical examination of the correlations between demographic characteristics and attitudes towards mediation, hence ensuring objectivity and generalisability..

Population and Sample

The target population consisted of **patients with kidney or liver failure, their family members, health practitioners, and administrative practitioners** connected to healthcare settings where organ donation requests are relevant.
A total of **1,027 respondents** participated in the study.

Data Collection Instrument

A structured, self-administered questionnaire was developed specifically for this study. It was divided into two main sections:

1. **Demographic Data** – including age, educational qualification, and occupation.
2. **Attitudinal and Perceptual Measures** – consisting of 25 items assessing participants' feelings, fears, comfort levels, and willingness to request donations, as well as their perceptions of the mediator's role.

Responses were recorded on a **Likert-type scale** ranging from **1 (Strongly Agree) to 5 (Strongly Disagree)**, with some items reverse-coded to ensure accurate interpretation.
The questionnaire was pre-tested on a small pilot group to ensure clarity and reliability before large-scale distribution.

Data Collection Procedure

Data collection was conducted across multiple healthcare facilities and patient support networks. Participants were approached through:

- Hospital transplant units
- Patient support groups
- Professional health associations
- Administrative departments in medical institutions

Informed consent was obtained from all participants, and they were assured of anonymity and confidentiality. Participation was voluntary, and no incentives were offered, ensuring unbiased responses.

Data Analysis

Quantitative data were analyzed using **Statistical Package for the Social Sciences (SPSS)**. Analysis included:

- **Descriptive statistics** (frequencies, percentages, means, and standard deviations) to summarize demographic characteristics and response patterns.
- **Interpretation of mean scores** to identify the intensity of agreement or disagreement with statements related to communication barriers, emotional challenges, and perceptions of mediation.

The results were used to explore patterns in emotional responses and to evaluate the perceived usefulness of mediation in sensitive health communication.

Results:

- **Demographic Data**

Variable	Category	Frequency	Percent	Valid Percent	Cumulative Percent
Age	31 – 40	567	55.2	55.2	55.2
	41 – 50	372	36.2	36.2	91.4
	61 and older	88	8.6	8.6	100.0
	Total	1027	100.0	100.0	—
Educational Qualification	Higher Diploma	449	43.7	43.7	43.7
	Master’s Degree	578	56.3	56.3	100.0
	Total	1027	100.0	100.0	—
Occupation	Administrative Practitioner	303	29.5	29.5	29.5
	Family Member of a Patient with Organ Failure	117	11.4	11.4	40.9
	Health Practitioner	478	46.5	46.5	87.4
	Patient with Kidney or Liver Failure	129	12.6	12.6	100.0
	Total	1027	100.0	100.0	—

Age

The largest proportion of respondents falls within the age group 31–40 years, representing 55.2% of the sample (567 participants). This indicates that more than half of the participants are in early-to-mid adulthood, likely reflecting an active working-age population. The 41–50 years group accounts for 36.2% (372 participants), showing a significant representation of mid-career individuals. The smallest group, 61 years and older, represents only 8.6% (88 participants), suggesting fewer older participants in the study. Overall, the total sample size is 1,027 individuals, representing 100% of respondents.

Educational Qualification

In terms of education, Higher Diploma holders make up 43.7% of the respondents (449 participants). The majority, however, hold a Master's Degree, accounting for 56.3% (578 participants). This indicates that the study population is highly educated, with all participants having at least a higher diploma. The total number of respondents for this category is again 1,027, covering the entire study sample.

Occupation

Regarding occupational roles, the largest category is Health Practitioners, who comprise 46.5% of respondents (478 participants). Administrative Practitioners account for 29.5% (303 participants), indicating a substantial representation from non-clinical professional roles. Patients with kidney or liver failure make up 12.6% (129 participants), while Family Members of patients with organ failure account for 11.4% (117 participants). This diversity in occupation suggests that the study includes perspectives from healthcare providers, administrative staff, patients, and their families, giving a balanced view of the topic under investigation.

- **Descriptive Statistics**

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Do you find it difficult to talk to your relatives about your need for an organ donation?	1027	1	4	2.33	.983
Do you fear that asking for a donation might cause tension in your relationship with your family?	1027	2	5	2.60	.932
Does the thought of asking a family member for a donation make you feel embarrassed?	1027	2	4	2.34	.639
Do you feel guilty just thinking that someone might risk their health for you?	1027	1	5	2.50	.965
Do you avoid talking about organ transplantation out of fear that your request will be rejected?	1027	2	4	2.26	.552
Do you think that having a third party (mediator) could make it easier to ask relatives for a donation?	1027	1	4	2.14	.758
Do you feel more comfortable discussing donation if a mediator is present?	1027	1	3	2.01	.533

Do you believe that a mediator can help convey your feelings and concerns more effectively?	1027	1	4	2.24	.800
Do you think that mediation reduces the embarrassment of talking about donation?	1027	1	4	1.95	.939
Do you think that the mediator's role is important in sensitive health situations within the family?	1027	1	4	2.00	1.015
Do you believe that the outcomes of mediation could increase relatives' acceptance of the idea of donation?	1027	1	3	1.85	.767
Do you think that relatives would be more willing to listen if a mediator spoke on your behalf?	1027	1	4	2.09	1.139
Do you see that the mediator's involvement can reduce relatives' rejection of the idea of donating to you?	1027	1	3	1.85	.767
Do you think that mediation creates a fairer and calmer atmosphere for discussing donation?	1027	1	4	2.03	1.166
Do you believe that mediation helps facilitate collective decision-making within the family?	1027	1	4	2.09	1.139
Would you mind asking a family member for a donation if it was to save your life?	1027	1	5	3.10	1.172
Would you prefer to wait on the donor list rather than ask a relative for a donation?	1027	1	5	2.89	1.178
Do you consider donation from relatives to be a personally difficult and complex matter?	1027	1	4	2.70	.976
Have you ever felt torn between your need for a donation and your fear of asking for it?	1027	1	4	2.39	1.121

Do you believe that every patient has the right to ask relatives for a donation without feeling guilty?	1027	1	4	2.48	1.212
Do you support the presence of a social worker or psychologist to support patients when requesting a donation?	1027	1	4	1.56	.893
Do you see the importance of having awareness programs on how to ask relatives for a donation?	1027	1	4	1.47	.894
Do you believe that psychological preparation of the patient before requesting a donation is necessary?	1027	1	2	1.28	.451
Do you support that involving a mediator should be an available option for all patients?	1027	1	2	1.33	.472
Do you think that having an official communication form from the organ transplant center would make it easier for you to request a donation from your family?	1027	1	2	1.43	.495
Valid N (listwise)	1027				

The results show that participants reported a moderate level of difficulty in discussing their need for organ donation with relatives, with a mean score of 2.33, reflecting a noticeable communication barrier. This difficulty is accompanied by a certain fear that such a request could create tension within family relationships (M = 2.60), and a sense of embarrassment when thinking about asking a family member to donate (M = 2.34). Emotional burdens also emerged, as many respondents indicated feelings of guilt over the idea that someone might risk their health for them (M = 2.50). Furthermore, avoidance behavior was noted, with respondents tending to refrain from discussing transplantation out of fear that their request would be rejected (M = 2.26).

Regarding mediation, the findings reveal a generally positive view of the role a mediator could play in facilitating donation requests. Participants showed mild agreement that having a mediator could make the process easier (M = 2.14) and increase their comfort in discussion (M = 2.01). They also believed that a mediator might better convey their feelings and concerns (M = 2.24) and help reduce embarrassment (M = 1.95). Mediation was also seen as potentially important in sensitive family health situations (M = 2.00) and in increasing relatives’ acceptance of donation requests (M = 1.85). Respondents further indicated that relatives might be more willing to listen if a mediator spoke on their behalf (M = 2.09) and that mediation could reduce outright rejection of the idea (M = 1.85), create a fairer discussion environment (M = 2.03), and facilitate collective decision-making within the family (M = 2.09).

When it comes to personal attitudes towards asking for a donation, participants expressed moderate willingness to request a family member's help if it were life-saving (M = 3.10), though some preferred to wait on a donor list rather than approach relatives (M = 2.89). Donation from relatives was considered a difficult and complex matter (M = 2.70), and many respondents felt torn between the need for a donation and the fear of requesting it (M = 2.39). Views were divided on whether patients have the right to ask relatives without guilt (M = 2.48).

Supportive measures received strong endorsement. There was a clear agreement on the importance of involving social workers or psychologists to assist patients in making donation requests (M = 1.56) and on the need for awareness programs to guide patients in how to approach relatives (M = 1.47). Very strong agreement was observed for the necessity of psychological preparation before requesting a donation (M = 1.28), and for making the mediator option available to all patients (M = 1.33). Finally, participants strongly supported the idea that an official communication form from the transplant center could make it easier to request a donation from family members (M = 1.43).

Discussion:

The demographic profile of the study sample indicates that the majority of respondents were aged thirty-one to forty, constituting over fifty percent of the total participants. This age group probably includes people in their early to mid-20s, which is a time when people are actively working and able to make decisions. The second largest group was made up of people aged forty-one to fifty. This shows that there were a lot of people in the middle of their careers who may also have a lot of family and social duties. Only a small number of people who answered were sixty-one or older, which means that senior people were not well represented in the survey. The sample was quite well-educated, with everyone having at least a higher diploma. A somewhat bigger percentage of them had a master's degree, which shows that they were well-educated and probably more aware of health issues and organ donation. Health practitioners made up the largest group of people who worked in the field, followed by administrative practitioners. There were also smaller but significant numbers of patients with kidney or liver failure and family members of patients with organ failure. This range of professions adds depth to the study by bringing together professional thoughts with real-life experiences of patients and carers.

The results indicate that numerous individuals encountered a moderate level of difficulty in articulating their need for organ donation to family. This problem was frequently associated with a fear that such discussions might induce friction in familial connections, as well as emotions of humiliation around the request. Many people also felt guilty since they didn't like the concept that a loved one may put their own health at risk for their own good. Some people said they purposely avoided talking about transplantation because they were afraid their request would be turned down. This suggests that avoidance behaviour could make it harder to find donors quickly.

Even though there were emotional and social problems, most people thought that mediation could help with conversations about donating. Participants said that having a mediator could make the process easier, make it easier to talk to each other, and let people say what they really feel and what they are worried about. People also thought that mediation may help families have delicate conversations, make people less embarrassed, and make it more likely that potential donors would agree to give. The inclusion of a mediator was correlated with a decrease in rejection rates, a more equitable discussion atmosphere, and enhanced facilitation of collective family decision-making.

When asked about their personal feelings about asking for a donation, most people said they would be prepared to ask family members for help if it meant saving their life. However, some people said they would rather stay on the donor waiting list than ask family members directly. Participants found it hard to ask family members for money since it was both emotionally hard and socially complicated. Many of them said they were torn between their immediate medical need and their concern of putting such a burden on their loved ones. People had different ideas on whether patients had the moral right to ask for a donation without feeling guilty. This shows how complicated these decisions can be from both an ethical and emotional point of view.

The respondents strongly agreed with supportive measures. Everyone agreed that it was important to have social workers or psychiatrists help people ask for donations, as well as that awareness programs were helpful in showing patients how to talk to their family. It was widely agreed that psychological preparation before making a request was important and that all patients who needed a transplant should have access to mediation services. A lot of people also thought that using official communication forms from transplant centres was a good method to start donation talks within families that was less confrontational and more organised.

Conclusions

This analysis of the psychosocial impact of mediation on intended donation between relatives was based on the findings and implications from a multicenter study within families confronted with patient liver or kidney failure, and it appears that mediation mediates emotional and social dynamics involved in making requests for donations. The results demonstrate that the inclusion of a trusted intermediary can help mitigate some of the embarrassment, guilt or fear of family relationship damage often inherent in making direct asks. Mediation might feel like a more neutral and less adversarial environment to raise the question enabling relatives to handle request in ways that reduce cognitive dissonance, protect family coherence.

The study also shows that a mediator is likely to promote open line of communication, more empathy and the feeling of being in this together for family members. Direct confrontation removed, the mediator works to turn a fraught request for donation into a collegial dialogue where considering donation might seem more palatable. The findings highlight the potential benefits of incorporating mediators into the organ donation procedure, especially among immediate relatives to increase approval and limit emotional damage or family discord.

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