LETTER TO THE EDITOR

Postmortal or living related donor: preferences of kidney patients. Authors' reply

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We would like to thank Martínez-Alarcón *et al.* [1] for their comments on our study, especially for their efforts to make an international comparison. With regard to the differences found in both our studies, we agree that the shorter waiting time for a kidney cadaver transplant in Spain could be a possible explanation. In that respect, compared with other European countries, Spain may be the exception rather than the rule when it comes to cadaver kidney transplant waiting lists.

In reply to the authors' question on waiting time in the Netherlands, currently the average waiting time is 4.5 years. More specifically, the median waiting time for the participants in our study was 2 years (0–15 years). In our study, a shorter time spent on the waiting list correlated significantly with a positive attitude towards living kidney donation [2]. As pointed out in our article, from the perspective of 'the longer waiting patient', a negative attitude could be explained by cognitive dissonance theory; and the positive attitude of the 'new patient', by a large reduction in waiting time and avoidance of the morbidity and mortality of dialysis. Furthermore, it may be that 'new' patients are more likely to be influenced by the relatively recent 'pro-living kidney donation' transplant professionals' policies in the Netherlands: information booklets and videos are offered as standard, and attention is paid to the better graft survival rates of living kidneys. In this respect, we wish to comment on the reference made by Martínez-Alarcón *et al.* that Spanish transplant professionals have positive attitudes toward living kidney donation [3,4]. It is well known that attitudes often are not predictive of behavior. As Ríos *et al.* and Conesa *et al.* indeed suggested elsewhere this favorable attitude might not necessarily be followed by a real request for living donation [3,4]. Their reference to the study of Arias is important here [5]. This study shows that although most Spanish hospitals do not have objections to living kidney donation, it was not systematically offered to patients. Apparently, it makes a difference whether transplant physicians are telephoning family members to invite them for a consultation on living kidney donation as a standard procedure (as is the case in Norway), or whether transplant professionals are merely willing to start procedures once the patient (or his family) raises the topic of living kidney donation. Strikingly in this respect is Martínez-Alarcón *et al.*'s remark at the beginning of their letter that 'opinion studies of this type are indispensable if we wish to encourage living kidney donation'. In Spain, the question still seems to be 'if', or whether, to encourage living kidney donation, whereas in the Netherlands the question seems now to have become 'how' to encourage living kidney donation.

To conclude, it would be helpful for further understanding these matters to hear other countries' comments on the acceptance of living kidney donation, and, moreover, on how this translates into transplant centers' policies on the encouragement of living kidney donation.

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