

Rationally Speaking #177: Dylan Matthews on “The Science and Ethics of Kidney Donation”

Julia Galef: Welcome to Rationally Speaking, the podcast where we explore the borderlands between reason and nonsense. I'm your host, Julia Galef. With me is today's guest, Dylan Matthews.

Dylan is a senior correspondent for Vox.com where he writes about politics, economics, culture, and a bunch of other interesting things. I've been a fan of Dylan's writing for years. The impetus for inviting him on the show today was actually kind of unusual -- It'll be a bit of an unusual episode in that it's not about a body of work, per se, but rather about a personal choice that Dylan made last year, which is that he decided to donate one of his kidneys to a stranger.

I'm interested in talking about this choice as a case study in, first of all, how we should be thinking about our ethical obligations to people who are outside of our immediate inner circle of friends and family. Also, a case study in how we should think about risks and benefits of medical procedures, given the imperfectness of research and evidence. Dylan, welcome to the show.

Dylan Matthews: Thanks for having me.

Julia Galef: What was the impetus for you for deciding to donate? This was last fall, right?

Dylan Matthews: Yes. The surgery was August 22nd, end of summer, beginning of fall and I'd been planning to do it for a while. I'd been in the process of getting evaluated for about a year. I think ultimate credit goes to peer pressure.

Julia Galef: From anyone in particular? Was there a particular role model, or just, all the cool kids were doing it?

Dylan Matthews: All the cool kids were doing it! Three people in particular, who are friends, who had done it. One is Alexander Berger, who you've probably met ...

Julia Galef: Mm-hmm.

Dylan Matthews: ... who is an analyst at Givewell, who works on a variety of topics.

Julia Galef: Definitely a cool kid.

Dylan Matthews: Definitely a cool kid. He's one of those cool kids. He donated his kidney back in 2011, when he was right out of college, and could testify that it was a manageable procedure, that it wasn't unduly burdensome for him, that recovery wasn't that bad, and that the benefits are substantial.

He introduced me to a guy named Josh Morrison, who runs a non-profit called WaitList Zero, which works specifically on living donors for other

organs as well, but mostly kidneys. Josh had also done a non-directed donation to someone he didn't know, and works on promoting that. Josh and I have become friends through this process.

I think one of the more influential people was my friend Ben Strauss, who -- unlike Josh and Alexander -- is not a self-identified effective altruist, who's not someone in a rationalist frame of mind, trying to sort through these issues methodically. He's a guy with a job, who read a Larissa MacFarquhar article on this phenomenon of people doing non-directed donations, and decided that that was something he wanted to do.

I think what was influential for me is: Andrew and Josh are professional do-gooders. Alexander gives out money from a foundation to effective charities and foundations. Josh runs one of those effective non-profits. Ben works at Facebook. He's a great programmer and a great administrator and very talented in many ways. He's a normal guy who just took time out his life to do this.

I mean this in as non-disparaging a way as I possibly can, but it was like, "If he could do it, this isn't some that like weird moral saints do it." It's something that Ben does.

Julia Galef: You don't have to have a shaved head and a robe and live on the top of a mountain and abstain from all pleasure.

Dylan Matthews: Exactly. I drink with Ben most weeks.

Julia Galef: That's great. You donated a kidney and you can still go drinking with him.

Dylan Matthews: Exactly. Yeah, that's a common ...

Julia Galef: It's pretty normalizing.

Dylan Matthews: ... misconception. Yeah. Liver transplants are rougher for that. I had a beer a couple days after I got out of the hospital.

Julia Galef: Nice.

Dylan Matthews: I don't know if that's a great idea, but it felt ...

Julia Galef: Just a reminder to all of our listeners that neither of us are doctors. We're not giving medical advice on the show.

Dylan Matthews: No, caveat emptor.

Julia Galef: Yeah. Before we start talking about the calculus behind donating, why don't you just give us a sense of the procedure? How does it work? Do you meet

your recipient? Is it totally anonymous? How serious, or how intensive is the procedure, and the recovery time, et cetera?

Dylan Matthews: The first thing to say is that I'm really unusual. The three people I just mentioned are very unusual, too, in that the vast majority of kidney donations are to someone you know already, usually a family member, sometimes a friend.

We're talking about a small subset where someone is donating without a specific recipient in mind. Some of those happen through, almost like dating web sites, that exist -- that people will post profiles saying they're looking for a kidney. People will scroll through them and pick someone. That's not a ...

Julia Galef: OKkidney.com?

Dylan Matthews: Right, exactly. I was uncomfortable with that for a number of reasons. One is there's something vaguely distasteful about people who need certain ... what I think of as a necessary basic medical procedure, begging for that... that seems like something you shouldn't have to do.

Also, the other reason is that it doesn't enable what I think is one of the coolest things about non-directed donation, which is donor chains. A big problem in kidney donation is that often times people will have a loved one, or friend who wants to donate to them, but just medically can't.

Different blood types is one issue, but you have tons of antibodies in your body that come into play when you're taking an organ from your body and trying to make it not reject in another person's body. It's very, very, very common even if you have the same blood type for it just to not work.

It used to be that if you didn't match, you didn't match. But some smart economists and doctors -- Alvin Roth is one of them who works at Stanford and got the Nobel a few years ago. Dorry Segev at Johns Hopkins has worked on this as well -- have developed algorithms for matching.

The simplest one would be a pair trade. If there's one guy out of people, a would-be donor and a would-be a recipient who want to donate, but can't, and then another one, and the first dyad's donor is compatible with the second dyad's recipient and vice versa, then they can just swap. Chains let you do that kind of a process on an iterated basis.

The difficulty is if everyone in the chain needs a kidney back, it's very, very difficult to set that up. I'm not good enough with math to know what adverb is correct for how fast it grows, but it's computationally much more difficult the bigger you get it.

One way around that is if someone in the process doesn't get a kidney back. If someone like me donates a kidney to a recipient and then they have a friend, or loved one who can donate, then they can donate it forward. The next person can donate it forward. It either terminates at some point, or it can just be left open ended.

There is one chain that opened a few years ago, I think is now closed, that had 30 donors and 30 recipients. These do go on for a very, very long time just because you don't have to loop it back around.

Julia Galef: Interesting. It's such an interesting way to do a large amount of good. It's basically injecting some liquidity into a system to allow all this good stuff to happen that couldn't happen ...

Dylan Matthews: Exactly.

Julia Galef: ... just because it's missing a bit of liquidity.

Dylan Matthews: Yeah, it's solving a liquidity problem. Yeah, it's an interesting application of very abstract matching theories. I think Alvin Roth, early in his career, did a lot of theorizing on this and then found that it was very relevant to kidney matching and very relevant to matching people for medical residencies, which is something else he's done.

Julia Galef: I want someone who worked on uberPool, or LyftLine to create an algorithm that pairs people for non-directed donation the ideal way, the same way like the app will just figure out exactly which driver should pick up which passengers to minimize the total amount of travel time.

Dylan Matthews: There are some more impressive algorithms that -- Uber and Lyft, my understanding is the driver still has to accept the suggestion that that's who you should also pick up. They have to go along with it.

There was this now defunct start up called Split in D.C. that had used this algorithm that I think a group of Finnish computer scientists had evolved, that did it with no driver choice. You pick up the people it tells you to pick up, no matter what.

Their claim was that it was vastly faster and it made both more shared rides than uberPool, or Lift Line. It's their corporate PR line, but... Yeah, there are a lot of interesting problems in that vein.

Julia Galef: Also it's going to allow us to use the phrase, "It's like Uber, but for kidney donation," which is always fun.

Dylan Matthews: Exactly. To get VC money for it.

Julia Galef: ...You can tell where I live.

Dylan Matthews: Yeah, yeah, we get a little less of that here in D.C.

Yeah, that was a major motivation for me. I did my surgery at Johns Hopkins, which has been a pioneer in doing chains like that.

I went in not knowing anything about who was going to get it, up until pretty late in the process, since they needed to match me against people I was compatible with. But then which one of them got my kidney had to do with when their loved one was free to donate, when I was free to donate. There are a lot of variables.

Ultimately, I got put into a chain that had four kidneys in it. It's closed now, but the final recipient didn't have a family member, or a friend who wanted to donate.

So, that all happened simultaneously on the same day. I had my kidney taken out early in the morning. It was flown to Cincinnati where my recipient lives. It was implanted there. At that same time, his friend, or family member was getting their kidney out and shipped.

They do these all simultaneously so that there's no chance of backing out. It wouldn't be like I gave my kidney and then the person's friend was like, "We got ours, I'm out." It enforces credibility in a certain way.

It's a huge logistical challenge. I was just consistently impressed throughout the process at their ability to pull it off, down to specific things like chartering planes at the last minute...

Julia Galef: That is really impressive. How long was your recovery after that?

Dylan Matthews: I'll put it this way. There are two or three days that are really exceedingly unpleasant. I don't want to say, "It's the worst pain you will have until you're elderly," because maybe half your listener base might deliver children at some point... but I think for men, it certainly would be one of the more painful experiences. It is major surgery. You're taking out an organ. You're making major incisions into your abdomen. That takes time to heal. I think, also, it's done laparoscopically, which makes it less invasive. They have one

Julia Galef: Sorry, what does that mean, laparoscopically?

Dylan Matthews: Sorry. Laparoscopic surgery is the surgical technique that's become really popular in recent decades. It lets you do smaller incisions. I had three incisions. One, was just big enough to fit a kidney out of around my belly button. The other two were for a scalpel, and a light/camera.

The addition of the camera and putting the instruments in through a tiny port lets them see what's happening and make the cuts they need to make

without opening up your whole abdomen, which was the way they used to do it, which would leave you with a scar all the way up to your chest.

It's a great technology. The difficulty in recovering is just so they can see the lay of the land in the abdomen, they pump your stomach full of CO2. It lifts the skin up. They can see around, see what's happening.

It turns out that getting CO2 reabsorbed into your skin is super painful. I'd not fully been briefed on that. The hardest part is just having it around in your system -- since gas rises, it will pinch your I forget which nerve it is, but it's a nerve that goes from your diaphragm up to your shoulders. So weirdly, I had this piercing shoulder pain that's not treatable by opioids, from gas activity lower in my abdomen

Julia Galef: Bodies are so weird.

Dylan Matthews: Yeah. My main memory from the hospital is I hacked my hospital bed, so that I was backwards, so the gas would flow downwards.

Julia Galef: That's clever.

Dylan Matthews: Yeah, I figured that out after a little bit. Yeah, I spent most of my time upside down watching Family Feud...

Julia Galef: Do you now have traumatic associations with Family Feud?

Dylan Matthews: No, it was a comfort compared to getting catheters put in and taken out, and the various indignities of hospital stays.

Julia Galef: Yeah, been there.

Dylan Matthews: Yeah. I was in the hospital for three nights. I went in on Monday morning and was discharged on a Thursday. After that, the recovery really is rapid.

It starts really bad, but it gets wildly better each day. You hit a point, about three or four weeks after where you just feel normal again.

I was told this would happen. It seemed totally unbelievable in the immediate aftermath of the surgery, just because I was so uncomfortable and so out of sorts. It really does happen remarkably fast.

I wound up only taking two weeks off work. I had originally planned to work from home for my first week back. I didn't wind up having to, which was really nice since I'm more productive in the office.

Yeah, it was a much easier recovery than I had feared in the grand scope of things. It's hard for a little bit, but a lot easier if you zoom out.

Julia Galef: This is probably a good time to talk about how you evaluated the risks.

Just naively, before looking at any of the evidence, one might assume: giving up a major organ is probably bad for you, or it makes you more vulnerable. I imagine you looked at the literature. What was your conclusion?

Dylan Matthews: My conclusion is that it's pretty safe.

I mean, it's major surgery. No surgery is risk free. There are two big risks that I think you need to think about in evaluating this.

One is the very near term chance of death, or serious injury in surgery. That just isn't very high at all. If you don't have high blood pressure, the risk of death in surgery is about a 1.3 out of 10,000 according to the literature I've seen.

That's about the same as childbirth in the US. Childbirth is not a risk free procedure either. There's a reason we congratulate mothers who are happy and healthy after the process. It's also something that it's a risk that people are readily accepting. It gives them a standard of comparison.

I was not super worried about that. It's also, I believe, under the homicide rate for D.C.

Julia Galef: I don't know whether I should feel comforted by that.

Dylan Matthews: Major cities aren't very safe.

The bigger thing is long term risk of chronic kidney disease. This is something that we actually learned a lot about in recent years.

It used to be that no one thought there was much risk of increased kidney failure. That has changed. The earlier studies have compared people who donated to the general population. You have about a third of the risk of developing kidney failure as the general population. I think it's about a .9% lifetime risk if you donated.

Julia Galef: Wait. Sorry. You're saying the risk of kidney problems, if you have only one kidney, because you donated one, is a third the risk of ...?

Dylan Matthews: Of the average American. Here's the caveat: The caveat is that to donate, you are selected for a variety of health measures. So the relevant comparison is not to the general population, which does look very good and looks like you're actually better off. It's to what you would be if you didn't donate.

A more careful study compares people who donated to people with equivalent kidney function pre surgery, who didn't donate, and shows that your risk goes up about eight fold.

Julia Galef: From what?

Dylan Matthews: From about 0.14% to .9%.

Julia Galef: Of kidney failure, or of ...?

Dylan Matthews: Yeah, of kidney failure. You have about a little under a 1% chance of kidney failure at some point in your life if you donate a kidney. Whereas, you'd have about a 99.9% chance of not getting it if you hadn't donated. The risk is small.

Yeah, you were going to say something?

Julia Galef: Sorry, I was just going to say -- I did read about one study. I had thought about the confounding problem, of if you're just comparing donors to non-donors, then yeah, those aren't the same group, so I was aware of that. But I came across a study that seemed like -- if it were well-conducted, I'm not really sure -- It seemed like it would get around the confounding issue.

That looked at World War II soldiers who had sustained an injury to one of their kidneys. You could consider that random, unless you think that people with better health are more likely to get shot in the kidney. I don't know.

Dylan Matthews: I don't think Nazi mortars

Julia Galef: Their long term outcomes, I think they were just looking at life expectancy actually, were comparable to people who had not gotten injured in one kidney. That was interesting.

Though I really don't know how much to update from a single study, which is actually something I wanted to talk to you about. Have you come across that?

Dylan Matthews: I had seen the World War II study. My sense is that the literature on mortality is much more sanguine than the literature on kidney failure specifically.

I think there was one Norwegian study that had a poorer research methodology a few years ago that claimed a modest reduction in life expectancy.

That's the only one out of a much broader literature. The general consensus is that there's not an increased mortality risk once you get out of the immediate post-surgical period.

Yeah, I worried much less about long term life expectancy. In any case, I think even if there was an effect on life expectancy, it would be totally

swamped by: how much sugar do you eat? How much do you exercise?
Compared to other behavioral modifications, it's just a drop in the bucket.

Julia Galef: Just to frame this process of evaluating the medical literature: the procedure that I usually go through -- and I haven't done anything quite like this, but in general -- the medical studies are really hard to do well enough that we can just be confident in the result. As I'm sure you know there's medical reversal that happens all the time, where we have a study that seems really good, or even an emerging consensus, and then it gets reversed 10 years later. It turns out, oh actually stents don't do what we thought they did, et cetera.

Given that fact, what I tend to do is I start with a common sense prior about, "What would I expect to be the case here, given just my understanding of how the world works?"

Like what I said at the beginning of this thread, "Probably, taking out an organ isn't good for you." Then, I look at the evidence. Depending on how strong it is, I update upwards, or downwards, from my prior to some extent. But I don't fully abandon the prior.

I'm wondering if you had a similar way of thinking about it, or if you think that makes sense.

Dylan Matthews: Yeah, I think I'm a less methodical Bayesian than you are in many ways. I hope to be a better one. I don't think I explicitly laid out my prior in doing the process.

Julia Galef: I don't think I would quantify it -- I didn't mean to imply that. I'm not that methodical! It's a qualitative framework.

Dylan Matthews: I think one thing that was helpful for me, in thinking this through, is the stuff that you are and aren't allowed to do once you've donated.

A decent estimate is that you lose half your kidney capacity immediately once you donate. Your remaining kidney grows a bit to make up for that. A decent estimate is you have about 60 to 70% of your prior kidney capacity.

The striking thing, talking to both of my own doctors and looking through the research, was just how few things that rules out for you. It really does seem like humans have evolved to have somewhat excess kidney capacity.

I think the only things I've heard about that affect my life at all, based on this, are most over the counter pain meds are overly taxing on the kidney. I have to take Tylenol, or acetaminophen from now on, and can't do ibuprofen, or aspirin. Which I'm fine with.

The other one is I lowered my Wellbutrin dose a little bit. I think that also upped another SSRI to compensate. It's very specific, weird stuff that, if

you're not taking specific medications, there's not a whole lot that's taxing your kidney and requiring 100% of your original kidney capacity.

I think thinking through that made it make more sense to me why there wouldn't be a huge mortality risk.

Julia Galef: Interesting. I'm tempted to segue now into how you thought about the ethics of kidney of donation, but just to make sure -- did you have anything else you wanted to make sure to mention about the risks, or procedure, or anything before we move on?

Dylan Matthews: No, I think we covered that pretty well.

Julia Galef: Excellent. Yeah, I think so too.

So I guess my first question would be: is part of why you made this decision because you think of it as, in some sense, morally obligatory? In the sense of, how can I justify keeping this kidney for myself, which I don't totally need, when someone's life is at stake? Was there a sense of moral obligation for you?

Dylan Matthews: I think obligation is not quite the right word. I like to think of myself as a scalar consequentialist and not a [plain] consequentialist.

Julia Galef: I like that – explain what that is?

Dylan Matthews: That's not my term. Alastair Norcross, who's a utilitarian philosopher at Colorado Boulder, has a paper called Scalar Consequentialism where he lays out this idea.

The basic concept is that once you get outside of the Judeo-Christian, or Kantian sense that what you want to do is distinguish between good actions and bad actions, and do more of the good actions and don't do the bad actions... If you think that morality is in some sense a tallying exercise --

Julia Galef: Tallying the goods against the harms?

Dylan Matthews: Tallying the goods against the harms, and then thinking through the consequences of your actions. That once you do that, drawing a bright line across the scale and saying, "Above this is good, below this is bad" is in some sense arbitrary.

It might make sense sometimes to do that. I think we have drawn a bright line about murder. It seems collectively useful and leads to better outcomes in the media in the long run. But there's no key principle of reason why that line should be one place rather than another.

Julia Galef: For example, why the line should be between causing harm, versus failing to prevent harm is like a typical intuitive way that people draw the line?

Dylan Matthews: Right, exactly. It also prevents you from drawing a line not between good and bad, but between “good, but not obligatory” and “good and obligatory.”

Julia Galef: The term that philosophers sometimes use for that is “superogatory” as opposed to obligatory. Where superogatory is like, “You’re not a bad person if you don’t do it, but if you do it, you get extra credit.” They’re like moral bonus points.

Dylan Matthews: I think some of this is -- Sam Scheffler wrote a book about this called *The Rejection of Consequentialism* that gets into this in an interesting way. He’s responding to the idea that utilitarianism is too demanding. It asks too much of you. His response is that you need to make the separation between things that are obligatory and things that are superogatory.

I think both consequentialism becomes more plausible, and it becomes easier to think of things like, “Should I donate my kidney?” if you just stop thinking in those binaries.

I don’t think anyone is morally obliged to give a kidney. I do think it’s better to do it than to not do it.

I am fully aware that because I am a human, with biases and flaws and imperfect information, that I’m never going to do all the things that it would be better to do than to not do. And I’m going to make some poor choices. My goal is to get higher on the scale, rather than to cross some threshold.

Julia Galef: Yeah. I think the way that I’ve been intuitively thinking about this -- I like Scalar Consequentialism. I may have to look into that -- the way that I’ve been thinking about it is in terms of obligation versus opportunity.

We talked about the “obligation” framing of morality, and the canonical example of that would be Peter Singer’s “child drowning in the pool,” a thought experiment where: if you would feel obliged to jump in and save a drowning child, even at the expense of ruining your \$1,000 suit, then -- if that’s your intuition there -- that shows that you should also feel obliged to donate \$1,000 if it could save the life of a child who doesn’t happen to be right in front of you, but is instead dying of malaria in a country across the world.

That kind of thought experiment, I think, underlies a lot of the sense of obligation that a lot of people, especially in the effective altruism community have.

An alternate conception of doing good, which is also relatively popular among Eas, is that of “opportunity.” You’re not really *obliged* to do any of

these good things. I mean, you're obliged to not murder and not really cause horrible harm to your immediate social fabric. But as you go around the world, you will encounter various opportunities to do good. You can ask yourself, "Do I feel excited about this opportunity?" One reason that you might feel excited is if it happens to involve a low amount of sacrifice on your part, or expense, relative to the amount of good it does, or it has some other feature that makes it a good deal.

I find that I often feel very motivated to do good when it feels like "this is a good opportunity; especially for me," or "especially for this particular case." In practice, it seems to work pretty well.

I think it's a tricky question whether that frame leads to more good being done than the obligation frame. But it seems to function basically well.

Dylan Matthews: Yeah, I think that's a really interesting question, and something someone who knows more about the social psychology literature than I do might have interesting observations on. Yeah, it's a choice between shame and guilt as a motivator and

Julia Galef: Excitement.

Dylan Matthews: Excitement and intrigue. I don't know. I don't have a strong prior as to which of those would be more effective.

Julia Galef: Yeah, nor do I. But in the absence of a prior, I feel totally free to do the one that I like better. That's how rationality works, right?

Dylan Matthews: That's right, kids.

Julia Galef: So how do you feel about the argument that donating a kidney does involve a fair amount of personal sacrifice, not just in terms of the pain, or the risk that you're taking on, but also in terms of the lost wages? You skipped two weeks of work. Not to get into how much you earn, but for different people who are sacrificing different amounts of wages, I could certainly imagine for many of them that there could be a lot of money that they could donate instead of taking the time off to donate a kidney.

Depending on what assumptions you want to make about how many lives you can save per \$1,000, it's plausible that you could save more lives just by donating the money that you would have lost by donating a kidney. What do you think about that?

Dylan Matthews: I think it's important to say, in my case, that I did not forego any wages for this.

Julia Galef: That's great.

Dylan Matthews: We have a very liberal medical leave policy. We also have unlimited vacation. The distinction between medical leave and vacation becomes very arbitrary. I was on paid leave for those two weeks. Vox Media was very supportive of that.

Julia Galef: Points to Vox.

Dylan Matthews: Yeah, points to Vox for that. Points to, I think, a lot of white collar employers have health policies like that.

Interestingly, the main concern they had was if I ever wrote about it, they didn't want the company to be seen as compensating me for having donated an organ.

Julia Galef: Does this count? You're not writing...

Dylan Matthews: I don't think it counts. I did sign a lot of paperwork saying it didn't count. The US has a lot of very stringent and not super consistent, or well thought through, laws about kidney compensation. We just wanted to be on the right side of that.

The lost wage issue is, I think, a totally fair point. But I do think there's sometimes a tendency among effective altruists to treat donations to effective charities as buying indulgences. To do it as an offset to not doing some other thing.

Julia Galef: I think some people would bite that bullet actually.

Dylan Matthews: I think they might, yeah. But you can both donate some money *and* do this.

I think, especially in cases like mine where there isn't a trade off between wages and giving, it gets murkier. But there were some out of pocket costs. My dad came down from New Hampshire and stayed at a hotel in Baltimore and looked after me. That plane ticket and hotel room were not free. I think it would be a very common sense policy to have hospitals compensate people for costs like that.

I think the total there was still well under whatever dollar amount you could estimate for the number of QALYs you're delivering.

Julia Galef: QALYs being "quality adjusted life years."

Dylan Matthews: Exactly.

Julia Galef: The lost wages argument is a special case of a general argument that donating a kidney may just not be the most cost effective way to help the world.

Even if you're not losing wages, someone could say, "It's still very effortful and maybe painful for you. Do you actually prefer it? If you could save the same number of QALYs by donating money, is there a reason to donate the kidney instead of the money?"

Dylan Matthews: This is an awkward thing to talk about, in that I think people have a bunch of hangups about this that don't make very much sense. I think there are a lot of selfish reasons to give away your kidney.

Julia Galef: Go on.

Dylan Matthews: There are more and less cynical versions of this. If you want to be hyper cynical, you gain a great deal of social esteem and prestige...

Julia Galef: Do you still gain the esteem and prestige if you *admit* that you are gaining the esteem and prestige? I don't know how this works...

Dylan Matthews: I think that does count against it! I should be clear that I'm denying on the record that this...

Julia Galef: Got it. For some other person who's not you, this could yield esteem and prestige...

Dylan Matthews: For some other hypothetical person who isn't me.

I think the less cynical version of that is it's a really emotionally meaningful thing to do. We sometimes have a hard time talking in terms of emotions in the effective altruism world. I feel a concrete connection to the person who got my kidney in a way that I don't to the specific people who got bed nets for money. I don't mean to be against Malaria Foundation.

Is that arbitrary and morally arbitrary? Sure. I think effective altruism has done yeoman's work in tearing down some of the feel-good assumptions about that. But it's still real. I still feel proud and happy that I went through that experience even just thinking about myself and my own well being.

Julia Galef: Yeah, I've thought a fair amount about this. It seems to me there are a couple of ways to justify using personal sacrifice as a reason to prioritize an act of doing good, as opposed to a reason to undermine that act of doing good.

One potential argument ... I'm very unsure how I feel about this, just to be clear. But thinking through arguments for this position, you could say that, "In the long run, I expect that I will do more good if I cultivate a character of someone who is willing to make personal sacrifices."

So even if, in this case, I didn't *have* to make a personal sacrifice to do good, I want to generally reinforce this virtue in myself, this personality trait of being willing to do this.

A different argument is more of a social influence one, as opposed to influence on yourself. That: maybe it's easy for me to donate \$5,000 to charity and save a life or two, but if I want to ask other people to help the world, it's not always going to be easy for them.

Maybe I want to show that I'm willing to do something that's hard for me in order to set a societal standard that people in general should be willing to do things that are hard for them. Or something. I don't know.

Dylan Matthews: Yeah, I think there's value to that.

I think also -- this is less in the cost column and more in the benefits column -- that I think it's important to include the social effects of donating. I wouldn't have donated if three people I knew hadn't donated before me, and hadn't served as an example. I don't know what the marginal increase in the number of future donors is from one person donating and telling people about it, but...

This is one reason we're working on a video with our video team, is that I think part of the benefit of doing it is increasing awareness of this, and maybe getting other people interested in doing it. So there's a benefit in serving as a personal example, in a way that is harder to do just for donating [money], just because donating is a less public act.

Julia Galef: And less vivid and salient and compelling as well.

Cool. Do you want to recommend if listeners are interested in learning more about this, is there any place they should go in particular that you'd recommend?

Dylan Matthews: The best compendium of basic facts and figures about this is Waitlist Zero, waitlistzero.org, which is Josh Morrison's group. They do great work walking people through the process. If you're interested in donating, I encourage you to reach out to me. I'm at dylan@vox.com. Or to Josh. Either of us are happy to talk to people considering this.

I also want to recommend a post that Josh and Thomas Kelly wrote for effectivealtruism.com. Go through the effective altruism argument for donating. The non flashy title is "Kidney Donation is a Reasonable Choice for Effective Altruists and More Should Consider It."

Julia Galef: That's a flashy title for an effective altruism blog! That's what we consider clickbait.

We can link to that post as well. Cool. That's probably a good place to break, or just to close. Now, you just gave a recommendation. Do you have another recommendation that you want to make your Rationally Speaking pick of the episode, that influenced your thinking in some way?

Dylan Matthews: This might be something that previous guests had mentioned as well... As we're speaking, it's a couple weeks after Derek Parfit passed away. He was probably the single philosopher who influenced the way I think about ethics more than any other.

Reasons and Persons in particular, which is a very technical and detailed read and might be tough for people without philosophy training. But it's really rewarding, really eloquent on this kind of point. It builds up to an argument that our distance from other people is not as great as we might think. Our relationship with our future selves is like our relationship with other people existing with us at the same time. An implication of this is that selfishness makes a lot less sense than it might seem to, and altruism makes a lot more.

That was a really influential and foundational book for me getting interested in philosophy and consequentialism. I think it's befitting in memory of Derek if more people went out and read it.

Julia Galef: I totally agree. He was very influential on me as well, especially the second half of the book that you were talking about. And very timely.

Dylan Matthews: Very timely.

Julia Galef: Thanks, Dylan. Thanks so much for coming on the show. It's been great having you.

This concludes another episode of *Rationally Speaking*. Join us next time for more explorations on the borderlands between reason and nonsense.