The Nasty Side Of Organ Transplanting

The Cannibalistic Nature of Transplant Medicine

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"Transplant technology may be compared to an evil genie let out of a bottle and now won't return." Nancy Scheper-Hughes, **Organs Watch**

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Contents

Foreword

It was a quote from Professor Geoffrey Dahlenburg of the South Australian Organ Donation Agency that got me interested in this subject. He said transplant coordinators would no longer be accepting a "soft no" from relatives who wouldn't agree to "donate" their next of kin's organs. He said, "If a family says no, we need to know why. In the past we haven't pursued that avenue. We've said that's their right and leave it at that. What we're doing now is still respecting that decision, but wanting to know why." [1]

Was this the language of voluntary benevolence? I began asking questions and the angelic tale of post-mortem benevolence soon resembled a cannibalistic saga. Government employees were pressuring families in their hour of grief to hand over gravely ill, brain-injured relatives so surgeons could begin removing their healthy, still beating hearts. Legal definitions of death had been expanded so that surgeons could avoid murder charges.

It would be irresponsible to pretend that all forms of body part harvesting and transplanting had the same implications therefore I would like to differentiate between the two different forms of harvesting and transplanting.

The first is the harvesting of bone, skin, and other body parts from a consenting adult who made an informed choice, was given full healing treatment while alive, whose body material was used for effective healing purposes, and who was completely dead prior to harvesting.

The other style of harvesting involves consent based on ignorance, harvesting begun while the donor is partly alive, and the organs and body materials used for ineffective treatments or to support neurotic pursuits such as lip and penis enlarging and neurotically based cosmetic surgery.

Chapter 1

An Invented Death

Transplant surgeons, just like movie vampires and Frankenstein doctors, like their bodies fresh and not quite dead. They need beating hearts in perfect health from warm, soft bodies to make the transfer of organs worthwhile. Their initial legal problem was that this process constituted murder of the donor.

The imperative of developing an artificial concept of death became apparent after Christiaan Barnard's historic heart transplant in December 1967. Barnard proved that heart transplants could be done, but had faced the problem of the risk of the donor heart damaging itself during the dying process.

Louis Washkansky was the world's first human heart transplant recipient. He was a Lithuanian Jew from the town of Slabodka who was deported to the Crimea when the Russians said the Jews were German spies. Louis later moved to South Africa and worked as a grocer.

Denise Durval, the world's first heart donor, was hit by a vehicle while walking to her car from a fast food shop in South Africa. Brain tissue began leaking from her ear. Denise was dying. Her father consented to the removal of her heart.

Louis Washkansky, desperately living each day at a time, was on the operating table. Hovering surgeons in full gown had opened up Denise, eagerly awaiting her heart to stop forever, but it kept vigorously beating.

Christiaan Barnard was worried the slow process of Denise's death would ruin her strong heart. Her brain was so damaged and a number of bodily functions were failing and Barnard was worried the heart in particular would suffer damage before it stopped.

When a person suffers what is called catastrophic brain damage the body temperature, blood pressure control, renal and endocrine function, and a variety of other processes progressively malfunction before the body dies, and it is this dying process that can ruin the organs. The heart is particularly vulnerable to damage during this process.

To avoid this natural shutdown medical technicians may inject a cardioplegic solution into the heart while it is still beating in the donor body. This action immediately stops the heart thus minimising the damage it may sustain as death progresses. The injection also gives it a longer shelf life before it is sewn into the recipient. It also kills the patient. Barnard couldn't do this in 1967 in South Africa because he would have been charged with murder.

When Denise's heart finally stopped, there was confusion in the operating rooms. Incredibly, Christiaan Barnard thought his brother Marius, also a surgeon, would remove the heart and he, Christiaan, would transplant it. It was resolved that Christiaan would do both, but by the time he removed Denise's healthy, pink heart it had declined to a morbid greyish-blue. It was put into a dish and taken to

the anaesthetised Washkansky waiting in the next room. There was a feeling of pessimism and doubt that this heart could be restarted.

But Barnard recounts that after a few electrical shocks, Denise's heart began beating strongly and pumping lifesaving blood throughout Washkansky's body, but he died anyway, eighteen days later.

The autopsy of Louis Washkansky's body showed that Denise's heart had transplanted perfectly and, despite the patient's death, surgeons around the world rejoiced at the world's first successful human heart transplant. But there was still another problem.

The South Africans had been lucky, but heart damage would likely still occur during future donor death processes, so it would be necessary to paralyse and remove the heart before it stopped naturally. The other problem was that in South Africa and most other countries, this was considered murder. Transplant surgeons, the medical hierarchy and drug companies needed a remedy to meet the demands of this brave new medical advance.

An Invented Death

After the Washkansky transplant, the Harvard Medical School set up an Ad Hoc Committee to Examine the Definition of Brain Death—or, rather, to invent a new style of death.

This committee of thirteen neurologists, neurosurgeons, lawyers, philosophers and an anaesthetist decided in August 1968 that death could be proclaimed if a patient failed to respond to a series of reflex tests. They called it the Harvard Criteria of Brain Death Test. This allowed a patient with a healthy, beating heart and fully operating renal and endocrine system to be defined as dead, just like a cold corpse. [2]

Most western countries adopted a de facto version of the Harvard Criteria of Brain Death during the 1970s and early 1980s. Some commentators say this new concept of death was devised to justify turning off expensive life-support machines used for patients not expected to recover consciousness. However, this new version of death was to the everlasting pleasure of transplant surgeons, who could now declare patients dead before their hearts stopped, then remove their vital organs and no longer worry about a murder charge. What one day was murder was the next day a brilliant surgical technique.

Surgeons began the harvesting process while the donor's beating heart was keeping the kidneys, liver, lungs and pancreas in optimum health and thus minimising organ damage during the dying process when heart function and circulation gradually collapsed.

The donor bodies were warm, pink and essentially healthy and the harvesting process killed the donor patient, but legally it was okay.

Combined with the Washkansky breakthrough and, more importantly, Barnard's second 1967 heart transplant into Phillip Blaiberg, who lived eighteen months, this legal "brain death" provided the impetus for the rush towards mass

transplanting. The introduction of cyclosporin in 1983 gave the transplant industry its next big boost.

The Brain Death Test

The prime candidates for organ harvesting are usually those suffering catastrophic brain trauma, with haemorrhage and swelling caused by car and motorcycle smashes, cyclists or pedestrians hit by cars, gunshot or knife wounds to the head or simply being hit in the head. In these instances an artery is broken within the skull. Surging blood spills into the skull but with nowhere to go the pressure builds up in the brain and may force the brain stem downward. With little blood leaving the brain very little can enter. Circulation slows in the brain and its cells run out of oxygen resulting in brain damage and eventual death.

Brain damage from oxygen deprivation due to heart attacks, heart failure, asphyxiation from smoke inhalation or strangulation where circulation of oxygen rich blood to the brain stops, causing global cerebral ischemia, may also make a patient a harvest candidate.

The body reacts to these injuries by shutting down functions and going into a deep coma where breathing may cease resulting in death. Ambulance crews reacting in time will blow air into the patients' lungs until they reach the hospital where a specialist will probably put the person on a mechanical ventilator to artificially maintain the patients' breathing.

Ambulance arrivals in this condition alert hospital staff to treat the patient with two views, the first being to aid recovery from injuries and, secondly, that they have a potential candidate for organ harvesting. Hospital staff may check the organ donor register and personal belongings for donor registration. The transplant coordinator may even contact next of kin and prepare for tissue matching before the patient is declared brain dead.

Depending on the country, hospital staff may spend four hours observing the patient for signs of recovery. If recovery isn't forthcoming a doctor performs the first brain death test and, if "brain death" is indicated, then a few hours later another doctor performs a final test.

However, there are many varied protocols around the world to the above that are rarely, if ever, enshrined in legislation. This allows doctors to devise their own methods to determine brain death. For example, the United Kingdom Code of Practice doesn't specify time periods between tests and repeat testing may be a formality.

The Australia New Zealand Intensive Care Society (ANZICS) recommends a series of tests but the doctor doesn't have any obligation to use them. The Society refused to provide their recommended criteria for brain death testing perhaps demonstrating how the transplant industry doesn't want potential donors to be informed on the subject. After this monograph was published on the Web they quickly added their recommendations to their web site. However, these do not include the controversial apnoea test. ANZICS cannot decide whether it should be used or not. [2a]

The Test For Death Begins

Doctors usually prevent relatives observing the brain death testing as they may object to the diagnosis of death or feel sickened by the physical rigour of the testing and the appearance that the doctor is harming their loved one. The test itself is not a pretty sight.

The doctor begins by shining a strong light into the patient's pupils. They should adjust in size to changing light and failure indicates brain injury. This won't be done if the eyes are full of blood. The doctor then holds the eyelids open and abruptly moves the head from side to side observing if the eyes move normally or remain staring straight ahead. This won't be done if the patient has a broken neck. The eyeball is poked with a cotton covered prod and painful pressure applied to the eye-socket to check for reaction. Failure to react in pain may indicate brain damage.

A catheter is stuck down the windpipe to see if the injured person coughs this being an indication of some remaining brain function. A probe is stuck into the mouth to check for gag reflex. The doctor turns the head sideways and pours 50 millilitres (two ounces) of freezing salt water into the ear. Salt water is colder than the freezing point of fresh water and when poured onto a delicate eardrum creates shock – to say the least.

Painful stimulus is applied to various parts of the body to measure arms, legs and trunk reaction.

Atropine may, depending on the country, be injected into the patient's blood stream. An increased heart rate of less than 10% indicates some brain death.

Some countries may also use the cerebral angiography where a dye is injected into the bloodstream and X-Rays observe the flow of blood to the brain. A lack of dye moving to the brain indicates a lack of circulation and possible brain death.

Dr Peter Doyle, of the British Department of Health, says the cerebral angiogram is unreliable and may register blood circulation in the brain one minute but four minutes later or earlier there might not have been any. [2b]

Another test is the Radioisotope Study where radioactive tracers are injected into the bloodstream. These radioisotopes emit radiation and their presence is detected by devices, like Geiger Counters, which respond to radioactivity. Since these radioisotopes are carried by the blood stream one can determine the flow of blood to the brain by the presence of radioisotopes inside the skull.

Many methods of determining brain injury are used around the world. There is no one perfect method because no reliable procedure for determining brain death has been invented. The difficulty in determining if patients are dead or alive may preclude them from being harvested.

Dr David Wainwright Evans from Queens College, Cambridge, gives some further description of angiograms and radioisotope studies in Appendix One.

The Apnoea Test

Doctor Turns Off The Breathing Machine

The Apnoea Test is the final procedure for brain death testing done to potential organ donors. If the patient doesn't respond sufficiently to the above mentioned tests the doctor turns off the ventilator, which has maintained the patient's breathing, and leaves it disconnected for up to ten minutes though it varies according to country and doctor.

Oxygen is pumped down the trachea into the still lungs, but the patient suffers oxygen deprivation because the ventilator is no longer raising and lowering the lungs. The theory behind this is that a brain that has recovered during the treatment in hospital will recommence the breathing process. However, if the apnoea test is performed just a few hours after admission then the theory becomes redundant.

If the patient doesn't begin breathing without the machine, the doctor declares the patient "brain dead" and re-starts the ventilator.

Second Brain Death Test

Before commencing the harvest a second doctor performs another brain death test. In Japan the second doctor waits six hours, in Spain twelve hours with adults and twenty-four hours with children. Australians wait two hours.

If the patient fails to respond to the second test the doctor certifies him or her brain dead. The patient is no longer considered a legal entity, has no human rights and is referred to as the "heart-beating cadaver". The ventilator is turned back on and the corpse, though legally dead, is kept alive on life support until surgeons have been assembled and transplant hopefuls brought to the hospital. This may take quite some hours or days.

All treatment to heal the injured brain will cease and doctors will administer high amounts of fluid drip, drugs to increase blood pressure and sometimes anti-psychotic psychiatric medications like chlorpromazine to maintain the harvestable organs. The patient, if it hasn't already happened, may be transferred to a hospital better equipped to harvest organs though this is universally denied.

Various Types of Brain Death

Most European countries and some American states recognise the "whole brain death" criteria that requires "irreversible cessation of all functions of the entire brain, including the brainstem" as defining brain death.

The United Kingdom, most Commonwealth countries and some American states, particularly Minnesota, went further and have adopted the lesser "brain stem death". The brain stem is situated between the brain and top of the spinal cord. It controls physical functions like breathing and regulation of blood pressure. The concept of "brain stem death" means part of the brain may be alive but when the brain stem is destroyed this is considered identical to brain death which is identical to being legally dead which is identical to being really dead, or so the logic goes.

Chapter 2

Donors May Need Anaesthetic

The residual doubts about the cadaver's health status increases when it reaches the harvest table. Let us assume it is a twelve-year old girl, diagnosed "brain dead", after being hit by a car while riding her bicycle. Her body is cleaned, shaved, tubes inserted and hooked up to various machines and everyone pretends it is a plain, dead corpse.

Donor Body Registers "Fear" to being Harvested

On the harvest table the surgeon draws a deep, clean slice down the middle of her torso cutting through skin, muscle and fat. But then a strange event occurs. Instead of lying dead and still like a corpse her twelve-year-old body registers fear and panic when the knife slices it open. Her heart and pulse speed up identically to a living human twelve-year-old cut with a knife

More violent reactions would occur but don't because the anaesthetist injects pancuronium or another paralysing drug. This prevents her torso jerking and arms and legs flailing about and what has been rarely described as coordinated attempts to "grab the knife".

Anaesthetists trained to prevent pain during surgery may assuage their doubts and the distress of other theatre staff by anaesthetising donors to prevent possible pain. But hospitals and donation agencies bitterly resent medical staff using anaesthetic because they spend their working lives trying to persuade distressed friends and relatives that the patient has actually died.

But many medical experts doubt this.

Professional Opinion

Dr Phillip Keep, a consultant anaesthetist at the Norfolk and Norwich Hospital in the United Kingdom, risked his career by publicly saying what the anaesthetist profession had been debating privately for decades,

> "Almost everyone will say they have felt uneasy about it. Nurses get really, really upset. You stick the knife in and the pulse and blood pressure shoot up. If you don't give anything at all, the patient will start moving and wriggling around and it's impossible to do the operation. The surgeon always asked us to paralyse the patient." [3]

Dr Keep adds,

> "I don't carry a donor card at the moment because I know what happens," [4]

Harvest theatre nurses also express doubt about the health status of the donor. Dr David Hill, also an anaesthetist, checked operating theatre registers at Addenbrooke Hospital in the United Kingdom and discovered that nurses recorded the time of death at the end of harvesting as if the donor had come in to the harvest room alive.[5]

Dr David Wainwright Evans, a cardiologist, formerly of Papworth Hospital in Cambridgeshire, England observes that,

> "Nursing staff treat deep coma patients with continuing tenderness and address patients by name, as the coma deepens rather than lightens, perhaps from an intuitive feeling that hearing has been retained."

Dr Evans says surgeons tell of persistent uneasiness at the unpleasant job of harvesting organs, particularly the heart. He says they don't get over it despite doing it many times.[6]

The Swedish medical writer, Nora Machado, quotes one expert as saying,

> "…Even surgeons are sometimes heard to say that the patient "suffered brain death" one day and "died" the following day."[7]

D.A. Shewmon, Professor of Neurology and Paediatrics, University of California (Los Angeles) School of Medicine, in his presentation to the Linacre Centre for Health Care Ethics, also says some surgeons feel they are killing the donors.[8] When interviewed by the Australian Broadcasting Corporation he indicated a change of mind about brain death being the death of the patient.[9]

> *Wendy Carlisle:* So is brain death the death of the person, in your opinion?
> *Alan Shewmon:* I used to think that it was. But in fact, during the 1980s and early 90s I read a number of articles and gave lectures supporting that idea, and since then I have had to change my opinion about it due to an accumulation of evidence to the contrary....
> *Wendy Carlisle:* I think you've actually called somewhere the notion of brain death a medical fiction.
> *Alan Shewmon:* A legal fiction.
> *Wendy Carlisle:* A legal fiction. What does that mean, then, in your opinion for the whole donor debate?
> *Alan Shewmon:* I guess it's also a medical fiction. You're right.

Dr David Evans is among a number of medical professionals who doubts that all organ donors diagnosed "brain dead" are actually brain dead,

> "The reason why the heart goes on beating in patients pronounced "brain dead" is, usually, that their brain stems are not really and truly dead but still providing the "sympathetic tone" necessary for the support of the blood pressure. In other words, the state of "shock" (profound hypotension) that characterises the destruction of the brain stem has not occurred in those patients."[10]

Dr David Hill concurs saying,

> "A measure of life is the continuing hypothalamic function which controls body temperature. If the patient is warm then that part of the brain is functioning."[11]

Despite scientific advances there still isn't an absolute determination when a person is finally dead

Japanese cardiologist, Dr Yoshio Watanabe adds,

> "…if the entire brain including the brain stem has indeed sustained irreversible damage, cardiorespiratory arrest would inevitably ensue, bringing about the person's death. However, the duration of this stage may well last for several days to several weeks when a respirator is used and hence, this stage at best only predicts that death of the individual is imminent, not that it is confirmed. The fact that some brain dead pregnant women have given birth to babies can be taken as strong evidence that the person is still alive, and the use of terms such as biomort or heart-beating cadaver is nothing but a sophism to conceal the contradiction in transplant protagonists' logic.[12]

Medical and government authorities in the United Kingdom are now trying to stifle professional debate and public knowledge by telling medical staff in the government health system not to define death and avoid terms like "brain death". The new term is "certified dead" which avoids uncomfortable medical definitions that are difficult to defend or explain. Death is then when a doctor says the patient is dead, regardless.

But once an idea based on fact gains credence no power can crush it. It was Drs Basil Matta and Peter Young, who wrote the now famous editorial in "Anaesthesia", the journal of the British Royal College of Anaesthetists, recommending the use of anaesthetic to prevent possible pain in donors,

> "The act of organ donation is a final altruistic one and we should ensure the provision of general anaesthesia at least sufficient to prevent the haemodynamic response to surgery."[13]

Chapter 3

The Apnoea Brain Death Test May Kill Patient

As disquieting as the possibility that donors may feel pain during organ harvesting is a body of scientific research opinion that says the brain death test not only falsely attributes death to the donor but also injures the patient and delays crucial treatment.

Associate Professor Cicero Galli Coimbra, Head of the Neurology and Neurosurgery Department at the Federal University of Sao Paulo, Brazil has completed the study, ***"Implications of ischemic penumbra for the diagnosis of brain death. Apnoea testing may induce rather than diagnose brain death".*** [14]

The study discovers that where there is brain damage there may be an area of the brain that is destroyed plus an uninjured section (even if there is no apparent function) and between the two a penumbra where brain cells are not functioning but recoverable. In severe cases a person may be wrongly declared brain stem dead or brain dead.

Coimbra's research shows that the testing for brain death both delays treatment for the patient and that the actual Apnoea test may bring on that state.

Coimbra shows there are two ways of treating severe brain injury that may produce recovery even in apparently hopeless situations. One is hypothermia that reduces the brain's use of oxygen and gives doctors more time to treat the patient before further damage occurs due to lack of oxygen.

Another is the controversial, and some say unproven, hyperventilation that is intended to increase the amount of oxygen reaching the brain. Both treatments are intended to minimise oxygen deprivation in the brain, hyperventilation by maximising oxygen reaching the brain and hypothermia by minimising the brain's oxygen requirements by slowing the metabolism.[15]

Coimbra and other critics claim apnoea brain death testing produces the opposite of the recuperative treatments and accelerates brain damage.

Tests to establish brain death require a normal body temperature and by taking the patient off the ventilator (though still pumping oxygen into the trachea) result in increased carbon dioxide levels in the blood. Coimbra shows this combination may be fatal to otherwise recoverable brain cells. [16]

For a more technical description by Dr David Evans see Appendix Two

Healing Treatments Denied To Potential Donors

Dr Yoshio Watanabe, an academic and cardiologist at the Cardiovascular Institute, Fujita Health University School of Medicine in Toyoake, Japan, writing in Beyond Brain Death[16a], states his considered view that applying the damaging apnoea test before hyperventilation and hypothermia treatment may constitute murder or at least a malpractice suit. He says a large fluid drip and drugs to increase blood pressure to maintain organs for harvesting actually accelerate brain injury. He says there are examples of apnoea tests repeated many times. In one instance a woman was brought to the Kochi Red Cross Hospital with a subarachnoid (and perhaps cerebral) haemorrhage. Instead of giving drugs to lower high blood pressure and using surgery to remove an intracranial hematoma doctors told the family, who needed to give permission for harvesting, that she was in the state of "impending brain death". A clinical diagnosis of brain death was made despite Phenobarbital administration that makes an accurate evaluation of brain function difficult. Surgeons harvested her heart, liver and two kidneys. [17]

In another incident at Osaka University Hospital in 1990 a crime victim was brought in with brain injury and three days before diagnostic tests were done for brain death doctors put him on a brain damaging treatment regime to keep his organs fresh and transplantable. This included drugs that elevate blood pressure, large amounts of drip infusion which rather than healing an injured brain "aggravate brain oedema, increase intracranial pressure and accelerate the process of brain death". Then they threatened his wife to agree to donate organs without telling her that the treatment to keep the organs transplantable would increase brain damage.[18]

Hypothermia

Dr Watanabe shares the view of associate Professor Coimbra of Brazil that hypothermia treatment should precede apnoea testing.

He cites reports from a team of neurosurgeons in the emergency care department of Nihon University Hospital in Tokyo [19]

They used computer controlled brain hypothermia with maintenance of adequate intracranial pressure to treat 20 cases of acute subdural hematoma with diffuse brain injury (collections of blood within the skull) and 12 cases of global cerebral ischemia due to cardiac arrest (lack of oxygen to brain because of heart failure). They were on the verge of brain death and going downhill but the team avoided the apnoea test in the fear of aggravating the brain damage. 14 of the 20 and 6 of the 12 recovered. Watanabe says this implies the hypothermia treatment gives a clear shift away from the point of no return and brain death.

Dr Watanabe says, based on the Coimbra conclusions that,

> "…a hastened judgment of brain death without trying such new therapeutic measures would well constitute murder, or at least a malpractice case. If all transplant protagonists try to ignore these observations, while at the same time claim the validity of current diagnostic criteria of brain death, and continue to give apnoea

> tests to aggravate ischaemic brain injury, I must conclude that the use of terms such as biomort or heart-beating cadaver is nothing but a sophism to disguise their real intention that the only thing they want is transplantable organs. They are not at all interested in saving those donor candidates.

Other critics in Japan say the apnoea test has been repeatedly performed there to achieve brain death rather than diagnose it.

Barbiturates Protect Brain Cells But Potential Organ Donors May Not Get Them

Barbiturates, for unknown reasons, protect the brain from damage when circulation has slowed or stopped due to brain injury or heart failure. People experiencing barbiturate overdoses have been known to go up to an hour without a heartbeat then revived without noticeable brain damage.

Barbiturates and other drugs also mask reflexes and brain activity making a living brain appear dead so a requirement for brain death diagnosis is that the patient isn't on these brain-protecting drugs. Therefore, patients registered as donors may be deprived of certain protective drugs so doctors can, with more ease, later declare them brain dead. This denial or withdrawal of protection allows the brain to become further damaged pushing it closer to brain death making it a disadvantage to be listed as an organ donor. A brain injured patient listed as a non-donor or organ keeper may get superior treatment in a hospital trauma unit than a potential organ donor.

A second problem is that barbiturates and other reflex depressing drugs may already be present in the donor candidate. This could allow sluggish reflexes, due to drugs taken before the injury, to be wrongly interpreted as brain damage.

Dr David Wainwright Evans says,

> "Barbiturates are protective – but the protocols envisage that such therapeutic measures will have been abandoned ere (before) testing for brain stem death is undertaken. That was the case in the early days. There was much discussion about how long one should wait to be sure that all such drug influence had cleared. Clearance can be very slow in some cases. Nowadays there is such haste to certify death for transplant purposes that barbiturate therapy is unlikely to be tried – but such (reflex-depressing) drugs may be present for other reasons and their presence may not always be suspected."[20]

Chapter 4

Organ Rejection

The human body rarely accepts the transplanted organ, seeing it as an alien tumour, and spends the rest of its life trying to kill it.

The immune system responds to a transplant with B cell anti-bodies, which can attack within minutes, and the new organ may turn black and blotchy even before surgeons have sewn up the wound. Invariably the organ and patient survive this immune attack and there is a brief "honeymoon period". The patient feels so improved and may be trotted out to the media to thank the doctors, nurses and donor family and say how fresh the air smells and that organ transplantation is a glorious experience.

The immune system ends this "honeymoon" when the T cell lymphocytes or killer T cells fully mobilise and attack what is sensed to be the alien and malignant organ. Transplant coordinators quickly shoo away the media because the patient no longer feels well or grateful for the transplant.

Doctors subdue this T-cell response by attacking and disabling the recipient's immune system with a series of toxic anti-rejection drugs.

The most popular immune-suppressant is cyclosporin. It is produced from a poisonous Norwegian fungus that attacks the immune system by disabling the killer T-cells. Not unexpectedly it has unusual side-affects like making gums grow over the teeth and increased growth of hair everywhere. Some patients leave hospital looking like apes and transplant patient guides even have sections on how to remove hair. Using cyclosporin is also an effective way to get lymphoma cancer and other deadly diseases.

Cardiologist Yoshio Watanabe says, "one cannot ignore the fact that cyclosporin causes hypertension, renal failure and left ventricular hypertrophy in 76% of recipients of any organ."[21]

Two biologically derived anti-rejection drugs are Azathioprine and OKT3. They are made by injecting human blood products into mice, rabbits and other animals whose own immune responses produce anti-bodies to kill the human anti-bodies. Lab technicians then drain the blood from these animals and isolate their anti-bodies that are fully primed to kill human anti-bodies. Doctors inject these aroused anti-human anti-bodies into the transplant recipient's blood stream and they surprise and devastate the killer T cells leaving the patient's immune system injured and unable to quickly attack and destroy the transplanted organ.

These drugs mentioned above plus other anti-rejection drugs like Cortico-steroids, Anitithymocyte globulins, cyclosporin, Tacrolimus (Prograf), also produced from soil fungus, and Mycophenolate mofetil collectively have side-effects such as kidney and liver failure, high blood pressure, high cholesterol, diabetes, hypertension, chipmunk cheeks, skinny arms and legs, large weight gain and bone marrow damage. Psychological effects may be exaggerated fears and panic attacks to the point of psychosis, blood and guts nightmares, wild

mood swings, bad tempers and hallucinations and insanity.[22] Steroids also cause vertebrae collapse and slipped disk symptoms which are treated with painkillers.[23] These are a few of the ghastly contra-indications of anti-rejection drugs.

Organ Recipients get AIDS-like Diseases

Organ recipients getting AIDS-like diseases is the open secret of the transplant industry, a secret they choose not to share with the donating public. Most recipients die of diseases caused through immune suppression rather than from transplant organ failure.

The immune system is not an optional extra and by weakening its ability to kill the transplanted organ it also becomes too weak to kill anything else. The patient becomes vulnerable to the same illnesses that kill HIV-AIDS sufferers. This means a common cold, a scratch, microbes from semi-cooked meat, raw eggs and uncooked dough may become a life-threatening disease. Transplant recipients can expect, and I emphasise, can expect, malignant cancer tumours caused by a suppressed and damaged immune function.[24]

Clint Hallam and The Thing

Clint Hallam was in a New Zealand prison serving time for financial fraud when he accidentally sawed off his hand. He joined a very short waiting list for hands and transplant coordinators found him a brain-injured boy in France. Doctors declared the boy "brain dead", sawed of his hand and sewed it onto Clint's stump.

Clint had a strong, healthy body and was overjoyed with the transplant until the anti-rejection drugs gave him diabetes. Then, to add insult to injury, the French hand attacked his skin and intestines in what is called Graft-Versus-Host Disease.

Clint might have accepted bad health and an ungrateful hand but The Thing looked so weird and failed to perform like a normal hand. It was soft, white and hairless, had little sensation and couldn't grip properly. Clint wanted to play piano and ride motorbikes, but The Thing couldn't do anything except look weird. Clint felt so silly he began wearing a glove over The Thing until it just got too much. Clint told the transplant doctors to chop the weird thing off.

They were furious. They wanted to complete the experiment. The drug companies were also angry, as Clint was what they called a post animal-model clinical trial subject, or, as we call it, a guinea pig. The first one.

The surgeons followed Clint's orders and sawed The Thing off. They had to. He had command of the mass media that were waiting to do a horror story on The Thing.

Now that The Thing has gone Clint has become healthier and stronger no longer needing anti-rejection drugs. He does have just one hand but The Thing was useless anyway.

Oddly enough, the surgeons had considered the transplant a complete success. Their aim was to transplant a hand. Clint Hallam's personal health was a secondary matter.

Matching Donors and Recipients

The ferocious reaction from the anti-bodies rejecting a stranger's flesh is minimised by matching the recipients and donors so that blood types are compatible and Human Leukocyte Antigen (HLA) tissue matches are as close as possible. Often based on a level of one to six the higher the antigen matches the less rejection the organ will experience. The immune system is less ferocious towards body tissue most similar to itself.

Immediate rejection is also reduced by catching the immune system by surprise and through injecting the recipient with anti-rejection drugs prior to transplant. Immunologists adopt a third precaution by avoiding transplanting an organ that has similar antigens to a previous transplant or even a blood transfusion because the immune system is already sensitised to these antigens and forewarned and forearmed against them.

A fourth factor is pregnancies. A woman's immune system initially reacts towards a foetus as a foreign growth that should be killed. The foetus responds, without damaging the mother, by disabling the woman's immune system towards it but not to other growths or infections. The danger is that a transplanted organ may have the same antigen characteristics as a woman's foetus. The immune system remembers this type from years before and is ready for the kill but this time the transplanted organ can't healthily disable the immune system attack, as did the foetus.

These factors have to be considered before a transplantable organ is allocated to a patient.

Louis Washkansky

It was pneumonia that killed Louis Washkansky. Denise Durvall's heart transplanted perfectly but Christian Barnard and his team used excessive cortisone to protect it from rejection. Along with pre-transplant irradiation this weakened Louis' immune system so that a minor infection, caused from holes drilled into his legs to drain excessive fluid, rampaged throughout his body. Barnard's team then over-used wide-spectrum antibiotics that killed a whole range of microbes but not the one they were aiming for. This left his body open and vulnerable. The infection got worse and turned to pneumonia. The patient's lungs clogged up, his feet turned blue and the famous Louis Washkansky was dead eighteen days after his historic 1967 transplant. [25]

Transplant recipients are never cured. Their life is like walking a tightrope between rejection of the organ and deadly diseases arising from immune suppression. It is exchanging one medical condition for another. And 95% of patients lose to one or the other. Inga Clendinnen says, in Tiger's Eye, of her transplant that,

> "We know that for us health is an artificial condition. We will remain guinea pigs, experimental animals for as long as we live or, if you prefer, angels borne on the wings of our drugs, dancing on the pin of mortality. We know that today is as contingent as tomorrow". [26]
>
> I go to the clinic every couple months. I count my pills, swallow them carefully. I intend to live. [27]

Christiaan Barnard said, "You cannot stay in the laboratory forever" [28] He, like Inga Clendinnen, was a realist and saw beyond the donation agency hype. There is always a point where a range of medical procedures are still experimental but that the donation agencies will try to persuade the public into thinking otherwise.

Chapter 5

Harvest Time

Battle For The Body

The fight between the relatives and harvesters over the dead body begins with who gets in first. The person lawfully in possession of the body can authorise harvesting of organs and other parts. But who actually has legal possession? In the first instance it is pro-harvest hospital staff that want to begin harvesting. Next of kin can gain possession by entering the hospital and legally take possession of the body. In some countries, like the United Kingdom, the body remains legally in the possession of the hospital while it is located therein which makes it more difficult to obtain it for cremation or burial or to avoid harvesting.[29]

Generally, in other countries, to gain possession one doesn't run into the room, punch out the doctors and grab the body. It simply requires stating one's next of kin status, mum, dad, child, spouse, etc and ordering what one wants done with the body.[30]. The hospital will send the body to the funeral parlour of your choice or, with your permission, consider it for harvesting. They may also request consent for a post-mortem to examine cause of death, which is frequently a ploy to remove parts as the autopsy consent form may have a tiny clause within, authorising organ and body parts donation. You can refuse this autopsy. If death has been sudden, unexpected or mysterious the Coroner can order a compulsory coronial post-mortem though this is relatively rare and may occur days later in a separate building. You can insist at this autopsy that no parts be removed for transplant purposes. Some Coroners act strictly as researchers trying to discover the reason for the sudden death while others are sneak thieves for the harvesters or medical schools.

Human Rights of the Heart-Beating Dead

The question of human rights for brain dead patients has never been fully determined by Australian courts. It is generally believed the corpse has no rights and that being brain dead is identical to being a corpse. It is under control of whoever has possession of it. As stated above hospital staff initially retain control until next of kin or, the person with designated power of attorney can be located. If neither party can be contacted within a reasonable amount of time the hospital can decide if the patient will be harvested even if they haven't registered as a donor. The hospital merely needs to say they have no reason to believe the patient was against being harvested. Australian transplant legislation rarely specifies what a reasonable period of time is though the 1964 Tasmanian legislation considered it six hours and this was before mobile phones were invented. In parts of the USA it is a more generous 24 hours.

In some circumstances transplant coordinators or hospital intensive care staff may locate grieving relatives and persuade them to sign consent forms even before the patient has been declared brain dead for the second time.

Different Versions of Brain Death

The procedures used to determine brain death are by no means universally agreed upon. In Japan loss of blood pressure is required to determine brain death because the brain stem regulates blood pressure. If the patient's circulation is still good the patient is considered to be alive. In Britain the blood pressure can be normal and the same patient declared brain dead and harvested. Bad luck.

Electroencephalography

Some of the states in the United States and some European countries require an electroencephalography (EEG) test to show that all electrical activity in the brain has stopped. Spain, on which the South Australian harvest and transplant program is based, requires two EEG tests twelve hours apart for adults and twenty-four hours for children. Two tests separated by time is protection against an initial mistake and the fact that brains don't stop like car engines but frequently re-start by themselves.

This careful Spanish approach contrasts with Australian practice where a person can be harvested within twenty-four hours of even turning up at a public hospital so there isn't time to do a second EEG.

But that doesn't matter because Australian hospitals don't use EEG testing using the argument that it is unreliable because a decomposing dead brain may give off flickers of electrical activity. Another argument, perhaps more true, is that an EEG may indicate the brain is still alive but this fact is irrelevant. Why? The key factor for declaring brain death is function, that is, whether the brain and the brain stem (section between the top of the spine and brain) can manage all the functions of the body. If it can't then the person will probably die sooner than later so we might as well cut out their organs while the body is still healthy, or so their argument goes. This utilitarian view operates using the premise that serious brain damage causing loss of bodily function is, for practical purposes, identical to death.

Another factor worth considering is the wide variety of techniques used to determine brain death. Highly skilled medical experts using the latest equipment still can't agree on the best way of determining when a person with a beating heart is actually brain dead because, apparently, they don't know.

Horrible Smell

Thus the possible consciousness of the patient is beside the point and, in any case, medical technology still can't determine the point when the consciousness of the human is completely gone and the person completely dead so we consider loss of bodily function the criteria for brain death. Less technological societies have perhaps a safer way of determining death. They initially consider loss of heart beat as death but keep the body safe for a few days until the odour of decomposition becomes apparent. Then they know the person is really dead.

Other countries don't consider any of the above brain death criteria valid. Pakistan and Romania and Orthodox Jews don't recognise brain death saying the

person is still alive. Thailand doesn't accept the concepts of "whole brain death" or "brain stem death" and any doctor caught harvesting a beating heart is charged with murder that carries a death penalty.

Kidneys From Really Dead Donors

The irony is that the most commonly harvested vital organ, kidneys, are still usable from completely dead donors whose hearts have stopped. In Japan, where harvesting from beating-heart donors is extremely rare, kidneys are harvested from fully dead people. Graft survival rate is slightly lower at 84.2 percent at one year and 72.7 percent at five years. Kidneys from fully dead organ donors aren't used in Australia but if they were there wouldn't be a donor kidney shortage. In Sweden, lungs are harvested from donors whose hearts have stopped for one hour alleviating the need to begin lung harvesting while the donors' hearts are still beating as is presently done in Australia and most other countries.

Chapter 6

Aggressive Hospital Harvest Teams

Most people have a cosy view of doctors and nurses warmly cooperating with each other to save lives. But reality is much different. Hospitals are stressful places for everyone and workers frequently end their shifts exhausted and disturbed. Doctors have higher than average levels of suicide and drug addiction. Many have worked and studied and been deprived of comforts to finish their education. They are dedicated and ambitious to gain new skills and invent new surgical and treatment procedures.

Transplant technology has the mystical lure for doctors of becoming rich, famous and respected like Christiaan Barnard, Denton Cooley and Norman Shumway. There is also the unspoken aim of transplant technology which is eternal life.

The transplant industry puts ferocious pressure on governments to increase organ supply so they can make more "heroic" attempts to do the impossible. When a brain-injured organ donor patient arrives it isn't just a million dollars worth of surgical activity at stake it is the reputations and life dreams of men and women who seek victory for the sake of themselves and their patients. From this boiler room of adrenaline and hyperactivity the declaration of patient brain death is like the firing of the starter gun at the Olympic one hundred-metre race.

The aggression temperature rises in this boiler room when two medical ideologies meet. Hindering the transplant faction's goals are those tending the brain-injured patients who try every desperate attempt to maintain life, occasionally beyond the dignity of the patient and financial capacity of the hospital. They are motivated by similar drives as the transplanters, that of pride, ambition and compassion. They hold an allegiance to the Hippocratic oath of maintaining life and doing no harm to the patient even when this patient is in the process of dying. They wish to see apparently terminally injured patients walk out of the hospital. These professionals, often neurologists and neuro-surgeons, are the impediments to transplant surgeons desperately pushing for an early diagnosis of brain death and subsequent rush to the harvest table.

Other enemies of those trying to maintain recuperative treatment for the potential donors are the transplant coordinators. They face similar pressures to obtain unquestioning consent from relatives and deliver what they call, "heart-beating cadavers" to the surgeons. They have the creepy task of looking through patient files to identify brain-injured patients, peeking through one-way mirrors at grieving families in the waiting room, and then meeting among themselves to decide who has the best chance of obtaining consent.

One is chosen. It is crucial for that person's career to obtain consent. The coordinator faces similar pressure to football players who need to score a goal in every game or are relegated to the minor league. Coordinators operate under similar motivations of pride, compassion, ambition and a basic desire to stay employed. The coordinator will push the relatives as hard as possible until there

is outright anger and aggression or until other hospital staff discreetly intervene with coffee or by telling the coordinator to piss off.

Doctors treating brain-injured patients face increasing pressure to declare their patients brain dead earlier and earlier. This is due to improving transplant technology, the rush of aging patients, little increase in donor numbers and financial reasons. Most transplants in Australia and other countries are corneal and kidney.

Some governments openly float the view that kidney transplants are cheaper than dialysis this being an impetus for their performance. A year on dialysis costs nearly as much as a kidney transplant that should last seven years. Another more popular view is that a successful kidney transplant improves quality of life though it may shorten that life if surgery goes wrong or the patient dies early from immune-deficiency caused diseases.

The cost of caring for sight-impaired or blind old people is another impetus for increased and earlier brain death diagnosis of potential donors. A cornea is cost effective when it improves the sight of a blind or partially blind senior citizen who might otherwise require continuous and expensive care. And accountants, and no one else, will see the financial benefit of the old person dying during or after cornea or kidney transplant surgery.

Transplant coordinators are under pressure to pursue government objectives which are to reduce public medical costs by increasing harvest and transplant rates.

Doctor Richard Nilges, Emeritus Attending Staff in Neurosurgery of the Swedish Covenant Hospital, Chicago, Illinois, USA recounts being pressured to declare patients dead for organ removal who later walked out of the hospital.

> "Committed as I was to the seriously injured or very sick patient under my care, whether he or she was brain dead or not, I had to literally fight off the transplant teams. One case I recall was when the transplant team was called to our community hospital without my knowledge and before I was ready to declare brain death on an unconscious patient who had a severe head injury in a motorbike accident. He had reflex extension of his arms and legs on painful stimulation. He was, therefore, not unresponsive even though his movements were no longer under the control of his will. His pupils reacted sluggishly to light. He had none of the criteria of brain death (except unresponsiveness). I rather too abruptly dismissed the transplant coordinator and his "team". I continued to treat this young man's brain swelling. He walked out of the hospital and returned to college" [31]

Same Day Harvesting and Aggressive Transplant Teams

Treating doctors previously had a minimum of forty-eight hours to treat the patient prior to brain death tests. This gave relatives time to discuss the issue of consent with religious guides and extended family. It also gave time to perform repeated safe electroencephalograph tests for brain life and allow time for a possible positive change in the patient's condition.

Now in the era of Day Surgery when patients don't even spend one night in hospital we have Same Day Harvesting. Half of all Australian donor patients are declared brain dead within 33 hours of entering hospital. 69% are harvested within 12 hours of brain death diagnosis and 98% within 24 hours. Queensland is the quickest to harvest incoming donors. It is possible to be harvested within 24 hours of being injured or suffering a stroke. Now that is fast service. [32]

Treating doctors around the world are reporting increased pressure to declare brain death before adequate periods of observation, treatment and self-recovery. Harvesters demand doctors administer drugs and prepare organs for harvesting despite this accelerating brain damage. This changed priority from treatment to harvesting shows that the fear recuperative treatment may be reduced for prospective donors is not a suburban myth.

Dr Richard G. Nilges, the retired Chicago neurosurgeon recounts more of his experiences.

> "With patients closer to brain death, the struggle was even more agonizing. The transplant team would be present in full panoply. The coordinator would object to my policy of two flat EEGs separated by 24 hours. I repeat his demand as I recorded it in a newspaper article: "Dr Nilges, you don't need another electroencephalogram tomorrow. Today's is flat. Declare death today". Of course, I did not declare death that day." [33]

Dr Nilges reports pressure to preserve the organs for transplant at the expense of the patient,

> "I grew weary of being at loggerheads with the demands of the transplanters when their demands were contrary to the interests of my patients. To preserve a suitable kidney for transplantation, transplant technicians would demand that I order what I would judge to be an intravenous fluid overload. I would refuse patiently and sometimes impatiently, explaining that too much fluid would cause more swelling of the already injured brain and might cause my patient's brain to die sooner. My commitment was to my patient, not to a faceless "society," to the next unknown (to me) patient on a waiting list. [34]

The pressure to prematurely declare patients brain dead isn't limited to United States and Australia. Dr Yoshio Watanabe, a cardiologist at the Chiba Tokushu-kai Hospital in Funabashi, Japan reports that,

> "…a 40-year old crime victim with a head injury was brought to the emergency room of Osaka University Hospital in August 1990, the team of physicians apparently looked at him as a potential kidney donor from the outset. Thus, as early as three days before the first diagnostic tests for brain death were made, they had started a set of new regimes (a combination of anti-diuretic hormone that reduces the urine volume, drugs that elevate blood pressure, and a drip infusion of a large amount of fluid) developed by this group, which is considered very effective in keeping transplantable organs fresh and viable. It would, however aggravate brain oedema, increase intracranial pressure, and accelerate the process of brain death. Without telling this fact to the victim's wife and by using words of threat, they persuaded her (in a manner far from an informed consent) to donate his kidneys.[35]

The above example was in 1990 but things haven't changed. Dr Watanabe reports on one of only four brain dead donors in Japan in a six-month period of 1999,

> "…a middle-aged female with a subarachnoid (and perhaps cerebral) haemorrhage. When she was brought to Kochi Red Cross Hospital, the physicians failed to give certain important life-saving measures, including administration of drugs to lower her extremely high blood pressure. Instead, they immediately told her family that she was in the state of ""impending brain death"" and did not explain the possibility of surgical removal of intracranial hematoma. A clinical diagnosis of brain death was made 60 hours after admission, disregarding the fact that repeated Phenobarbital administration could have made an accurate evaluation of brain function difficult. Preparations for organ transplantation were expedited…" [36]

Dr Watanabe reports that a subsequent review of the incident showed that repeated apnoea tests were done even before the electroencephalogram became flat. This is illegal in Japan but legal in Australia. The problem with the apnoea testing, as stated elsewhere in this book, is that it deprives the brain of oxygen and speeds up brain death. When it is done repeatedly one can suggest, perhaps reasonably, that it is being done to create brain death rather than test for it. [37]

Harvest Time

The rush to prepare the ex-patient and now brain dead cadaver for harvesting is interspersed with moments of silence. Hospital staff allow relatives to bid farewell to the cadaver or patient with the confusing status. It or he or she will be maintained on life-support, despite being called dead, until the harvest and transplant teams are assembled and compatible recipients located and brought to the hospital.

Doctors may have injected 20,000 units of heparin to prevent blood clotting. They may also have preserved the organs by putting the patient or corpse on a high fluid drip and inject drugs to increase blood pressure. They should wait until brain death is declared at which time two catheters will be inserted into the abdominal aorta and femoral vessels to flush out the blood from the organs with a cold solution. Theoretically no preparations for transplant organ maintenance should happen before the final brain death diagnosis is given and relatives have consented to harvesting.

The anaesthetist paralyses the donor body to prevent pain or panic reaction to being cut apart. While not routinely done anaesthetic may be administered to stop possible pain and to soothe medical staff fears that they are hurting the donor. Heart and pulse rate monitors may be turned off so staff don't see and hear the body's reaction to being sliced open. Tubes and drips are inserted and pumps started.

The surgeon slits open the donor's chest then saws up the middle of the breastbone with an electric circular saw. The surgeon pulls apart each half of the ribcage to expose the viscera and inserts separators to keep the ribs apart. A nurse or assisting surgeon pours ice slush over the surface of the organs. Chilled organs last longer just like chilled meat.

The heart is generally removed first with the lungs if both are going into the same recipient. Extracting just the heart requires two thoracic surgeons, an anaesthetist, two experienced nurses, one perfusionist and various stand-by staff and students. The donor's real death is frequently determined when the aortic clamp is applied and the heart paralysed. After being cut out the heart is rinsed of blood, perfused in a cold preservative and put in a picnic cooler filled with ice and coolant and rushed to the recipient's hospital. Heart and lungs go first since they last just six hours which can be difficult if there is a three-hour flight.

Another process is by removing the heart in a block of crudely dissected and cooled tissue from which the wanted organs are carefully dissected outside of the body by the specialised teams of harvesters.

Harvesting the donor's liver is particularly difficult and often involves massive bleeding where the corpse requires blood transfusions to keep it alive, or viable, or whatever. The liver and pancreas may be removed together and taken to a table just behind the main donor table where they are separated for two different recipients or, if not donated or needed, either put back into the body, thrown away or used for research. Kidneys are removed last due to the anatomy of the body and because their Use-By date is anywhere from 24 to 72 hours.

Transplanting surgeons may remove their particular organ and leave with the picnic cooler on a fast private jet, but usually there are separate harvesters and transplanters. The transplanters prefer to stay with the recipient and wait for delivery by road or aircraft. They may have lunch or sleep while awaiting the organ as transplanting can be a long, gruelling job requiring a high level of fitness while maintaining a subtle touch even whilst exhausted.

The Less Than Desperate Organ Courier

Most people have seen promotional images of harvest surgeons or nurses desperately rushing to an ambulance or aircraft to deliver the organ to a patient flickering on the edge of life and death. One can imagine the nurse sitting in a double seat of an aircraft carefully watching the temperature on an incredibly complex and expensive portable fridge. Actually, the organ, usually a kidney, is packed with ice and cooling liquid into what is called a picnic cooler or Esky. It resembles those six-dollar Styrofoam boxes used to transport broccoli sprinkled with ice to the morning markets. The organ is often sent by ordinary courier to the airport where another courier at the destination picks it up.

Harvesters regularly send kidneys across the Nullabor Plain between the Royal Perth Hospital in Western Australia and the eastern states. On one occasion a World Courier (Australia) Pty Ltd courier put a Styrofoam box on the plane to Adelaide thinking it contained a kidney. It didn't. He discovered the warm kidney in his van the next day after receiving an unpleasant phone call from the waiting hospital staff. The kidney was ruined.

Peter Hornsey, the expectant recipient, was waiting in the Queen Elizabeth Hospital in Adelaide. Doctors had already inserted a catheter in his neck and doused him with anti-rejection drugs. Peter was somewhat disappointed to say the least. Doctors pulled the catheter from his neck vein, sewed up the wound, sent him back home and back onto the waiting list.[38]

Reasons for Not Using an Organ

Organs are initially rejected if the donor is considered an infectious disease risk. This takes the form of infection discovered in the body or the hospital may have fears over the donor's disease history including social history problems such as homosexuality, pituitary growth hormone injections, being a transplant recipient or from recently being a "working girl". Further rejections may occur from receiving hospitals because of unusual physical characteristics of the organs, tumour presence, unforeseen damage during the event leading to brain death or by surgical error during harvest. Despite all the above organs are now being used in the United States from donors with a history of cancer.

Acceptance of organs varies depending on the country. Australia prides itself with the world's highest standards of infection control and won't accept a range of body products from other places including Europe and the United Sates. Australia's standards are uniform between states so an organ rejected in one hospital is likely to be rejected in another so after one rejection it is no longer considered.

In the United States standards vary so greatly between states and hospitals that a rejection in one place may be acceptable to another. When an organ is rejected transplant coordinators phone the next waiting hospital, giving them one hour to accept or refuse. This continues until the organ is either accepted or passes the use-by date and is discarded or, theoretically, inserted back into the corpse for burial or cremation. Business is business in the United States and every organ is flogged until even the most desperate hospitals reject it.

Use-By Times

The Use-By time for hearts or heart/lung combinations is five or six hours. Lungs separately are six hours. Livers up to 34 hours. Pancreas up to 20 and kidneys up to 72 hours. Corneas last ten days and can be harvested twelve hours after cardiac death. The above figures are from the monograph, *Using the Bodies of the Dead,* by Swedish writer Nora Machado. In *What Every Patient Needs To Know,* published by the United Network for Organ Sharing (UNOS), the American organ allocation outfit, it is written that livers last up to12-24 hours, kidneys 48-72, pancreas 12-24 and hearts and lungs 4-6 depending on the quality of harvesting, state of organs and care of preserving and transport.

The donors and recipients usually reside in the same city but organs and parts are flown to other cities and states. For example, South Australia doesn't have a heart transplant unit so their hearts go to the larger states. When there is a particularly good tissue match or an acute patient is quickly dying an organ may go interstate despite qualifying recipient hopefuls waiting in the same hospital as the dying donor. Patients awaiting organs may also be left in the lurch if their state is an organ debtor to another and that state wants payment immediately.

Skin and Bone Harvesting

Following vital organ removal there is no longer any doubt the patient is really dead. A new group of dismantling surgeons then continue a bloodier and less delicate harvest. They come from the Skin and Bone Banks that rent hospital facilities but get the remains for free. The following is representative of United States harvesting which is the most extensive in the world. Some countries don't allow commercial harvesting.

The dismantler using a knife cuts the scalp at the back of the head from ear to ear then, in an effort which requires some strength, pulls it over the face so it fits inside out with the hair on the inside. He, and it is usually a man, saws off the top half of the skull with an electric saw making a notch at the back so when it is replaced for the funeral it won't slip off and distress relatives. The skull top makes a slurping sound as the dismantler lifts it off. The harvester then removes the valuable Dura matter, the protective lining between the brain and skull. Depending on the wishes of the donor or relatives the top half of the skull may be replaced and the scalp and hair pulled back over to reveal the face. Otherwise jaw bones, inner ears and cartilage are removed making it impossible to display the face at the funeral unless covered with a mask resembling the face of the deceased.

Harvesters dressed in rubber gloves, hats and aprons strip, peel and cut skin from arms, legs, front and back of the torso or anywhere. They pull out and wash the valuable major leg veins and the muscle covering called Fascia. Dismantlers and autopsy crews slice out soft, silky urological tissue and report that human muscle smells like lamb meat. They remove trachea cartilage, ligaments and tendons. A prized sack called the pericardium, similar to Dura Matter and surrounding the heart, is taken and sold for repair patches that are placed over the brain after surgery. Both fetch high prices though dura matter has been subject to prion disease scares. Pituitary glands are left untouched due to their somewhat

mysterious and nasty history of transmitting the terminal Creutzfeldt-Jakob disease.

Dozens of valuable bones including the femur, acetabulum (hip socket), hemi-pelvis, humerus, radius, ground humeral, tibia, ulna, osteochondral bone, and cranial plate are taken for what is euphemistically called recycling.

Intestines are occasionally removed in the United States and other countries and transplanted, sometimes in combination with livers, but without great success. Intestines aren't transplanted in Australia and rectums are not transplanted here or in the United States. Rectum cancer is a major killer in affluent societies but one can imagine the public relations disaster for the industry if a recipient experienced a Graft-Versus-Host reaction.

It is the junior medical staff who clean the harvested intestines that smell like a combination of vomitus and faeces. They say the smell of gastric acid is unforgettable. You remember it to the day you die.

Funerals More Expensive

Open casket funerals can be a problem with so much of the donor corpse removed or damaged. Some bodies could more appropriately fit into a large bucket with a lid than a coffin. To create the image of a gently sleeping, fully intact donor morticians shove plastic piping up the cadaver's spinal cavity, legs and arms to provide bulk where the bones previously resided. In Australia they do it cheaper. Simon McLeod, formerly of the Glebe Institute of Forensic Medicine, also known as the Sydney City Morgue, said they used a broom handle on an elderly lady after removing her whole spinal column.

They also belted one murder victim with a hammer. He had a round fracture and staff suspected that he had been killed with a hammer. They wanted to see if the hammer wounds they inflicted were identical to those that killed him a few hours earlier. One can understand their rational.

The Sydney City Morgue also allowed a plastic surgeon to sneak in, without the permission of relatives, and practice doing nose jobs on the corpses. Imagine what relatives at a funeral would think seeing the newly deceased with a different nose.

Morticians plug the holes, fill the bodies with gel filler, tape and wrap the bodies and put them in a liquid and odour proof bag with just their faces and hands sticking out. Plenty of scarves, a favourite suit and, perhaps, sunglasses, will disguise the fact that the deceased has been partly skinned, de-gutted and deboned.

Morticians are artists and the immense challenge of fixing up harvested bodies is matched by their prices. Neither the transplant industry nor governments recognise the extra costs of funerals for relatives of organ donors.

Chapter 7

The Nurse's Tale

Transplant coordinators and donation agencies never tire of emphasising that the donor family's loved ones will be treated with dignity and respect. It is a comfort to think unaffected people with a higher cause dismantle the bodies. But an American nurse who has worked thirteen years in the transplant field in the United States says,

> "The families are led to believe they are doing such a noble and wonderful thing by donating their loved ones organs. I tend to believe, in their moment of grief, they are not thinking clearly. This is what happens.
>
> A patient is declared brain dead. The family gives consent to remove organs/tissue/etc. This body is trying to "die", but we keep it alive artificially till suitable donors can be found. Sometimes this can take many hours, as precise tissue matches are not always at the ready. Meanwhile, the body is deteriorating.
>
> My role in all this was waiting in the operating room. 'Are they ready to start this retrieval yet? No, they can't find anybody to take the heart (just an example).' So when they finally do find a recipient, teams come in from various parts of the country to harvest the various organs. The patient is brought to the operating room, and the procedure is begun. The heart is removed first, followed by the other organs. Sometimes an organ is not taken because there was no recipient, or it is taken just for research. Occasionally an organ is deemed unusable due to a disease process. Immediately after the organs are removed, the various doctors whisk them away in coolers, never giving a thought to the person who just died or the grieving family. They have no idea of even the person's name. So one by one, these ghouls leave the operating room till all that is left is the body, laying WIDE open, quiet, & cold, and the nurses.
>
> Usually some underling of a resident is left to sew the body shut. It is a hideous sight. And the smell of death is starting to permeate the room. Nauseating! So the body is closed, and that doctor leaves and all we have is the body and the nurses. It's left up to the nurses to clean up one holy hell of a mess, and take care of this body that has been defiled and forgotten. We must pull all the various tubes and lines out of the body to make it presentable for the family. As the tubes are pulled out, this horrible stench exudes from the depths of this former person. After all, he has been kept alive artificially, and his body has been trying to shut down naturally.
>
> As we are cleaning him up, we try very carefully not to slip and fall in the blood and fluids that cover the floor. I try to keep in mind that this could be my family member, and I take great pains to clean the body as best as I can before taking it to the morgue and yet keeping in mind the fine doctors that just left this nameless patient. They are flying home in their Lear jets, laughing and partying, awaiting their future glory for "saving" some poor suckers life with a transplant.

> Sorry to sound so glum, but I can't help but think if families could see how their loved ones were treated, they would never consent to the taking of organs."[39]

Chapter 8

Survival Statistics

Survival Prognosis

Transplant interests and organ donation agencies never tire of feeding the mainstream media stories like how a tragically killed teenage boy saved the lives of four or maybe five people by donating his organs.

The truth is usually different. Transplant coordinators or consultants face extreme pressure to obtain consent from relatives. Their careers and a million dollars worth of transplant surgery over the next twenty-four hours depend on the total unquestioning acquiescence from relatives.

The shocked parents are typically in sudden grief, often on sedation and haven't eaten or slept for the previous 24 hours. They see their terminally injured son or daughter lying apparently healthy in a hospital bed. Transplant coordinators or intensive care unit staff face the difficult task of convincing these parents to allow surgeons to cut and saw open this warm body with its beating heart and remove multiple organs thus preventing the natural dying process of their child. They subject the shocked, confused parents to every psychological trick of guilt, hope and intimidation to gain acquiescence to what could easily be seen as a barbarous request. The key propaganda line they hit the parents with is that numerous lives can be saved from this tragic death.

The lives saved are an exaggeration. Kidney transplants rarely save lives. They may improve a person's life by exchanging an unpleasant and dangerous dialysis and restricted eating regime for a more robust lifestyle that includes anti-rejection drugs and, sooner or later, kidney rejection. It may also kill the recipient during surgery or from anti-rejection diseases. Hardly life-saving surgery.

Kidneys are removed and transplanted for financial reasons. Dialysis can cost governments $50,000 annually for thirty years. A kidney transplant costs $70,000 with $10,000 annually for anti-rejection drugs. With luck, from the accountants' point of view, the patient will die or the kidney will last at least ten years. Kidney transplanting resembles a financial operation as much as a medical procedure.

Patients receiving livers from brain dead donors have a 20% death rate during the first year. Vital organ survival statistics beyond five years are suppressed because the death rate continues to increase.

With most illnesses a five-year survival rate after initial recovery is considered a permanent cure. There isn't a permanent cure with organ transplanting because the patient never gets better. The immune system rarely relents and slowly kills the organ or the person dies from immune deficiency diseases caused by the anti-

rejection drugs. These defeat 95% of transplants. So one can understand why the organ harvest promoters suppress long term survival statistics.

Fiona Coote and Professor Mario Deng

Every transplant country has someone like Australia's revered Fiona Coote. In 1984 at the age of fourteen doctors told her she needed heart surgery. She awoke with another person's heart inside her chest. Fiona was angry as doctors and her parents hadn't told her they were putting someone else's heart into her. Later surgeons replaced it with yet another heart.

The personable and inspiring Fiona is regularly "expressing the gratitude" of fellow heart recipients. She expresses their gratitude because they can't. Most are dead or too ill to either express or feel any gratitude. In fact half of all heart transplant recipients would have lived longer if they hadn't received the transplant in the first place.

In a landmark study, a team headed by associate Professor Mario C. Deng of Columbia University College of Physicians and Surgeons, New York, showed that many heart transplant recipients don't survive longer than those who were left on the waiting list. In the study, *"Effect of receiving a heart transplant: Analysis of a national cohort entered on to a waiting list, stratified by heart failure severity,"* the survival outcomes for all 889 adult patients waiting for a first heart transplant in 1997, in Germany, were measured over a three year period. [40]

Waiting patients were listed into three categories - those with a high, medium and low risk of dying while waiting for the procedure. Transplanted hearts go to patients with a high risk of dying while on the waiting list, but also to medium and low risk because these latter patients, with slightly less desperate heart problems, have a generally better chance of surviving the surgery and immune-suppressant diseases that follow.

Heart Recipients Died Sooner Than Those Who Missed Out

Associate Professor Deng's results showed that those with a high risk of death had a better survival rate than those left on the waiting list indicating the transplant extended their lives. But, surprisingly, those of medium and low risk who got transplanted hearts had a lower survival rate than those of a similar illness level who missed out on this supposedly lifesaving treatment. The conclusion of this study was that many patients lived longer with their bad hearts than those who got transplants.

Mario Deng's study conclusion that, on average, only the sickest heart transplant recipients lived longer has prompted suggestions in the industry that less ill patients should be treated by other means. It also prompts the obvious conclusion that the waiting lists are crowded with those who won't benefit from a heart transplant.

The results of Mario Deng's study have rocked the transplant industry and allow commentators to reasonably speculate that half of those receiving heart transplants don't experience an increased survival outcome over those of similar illness level who missed out. The waiting lists include many who won't benefit from a transplant.

Deng's study results add more weight to the views of English cardiologist Dr David W. Evans, who observed as early as 1982, that patients requiring life-saving open heart surgery were being left to die at Papworth Hospital while heart transplant patients took up the intensive care beds. Dr Evans said they lost 14 patients in an eighteen-month period this way.[41]

So Why Not Restrict Heart Transplants To The Very Sickest Who Need Them The Most

The United Network for Organ Sharing (UNOS) in the United States sensed the problem before Mario Deng scientifically proved it to the world. In 1998 UNOS changed its policy by giving increased transplant priority to the sickest patients. This meant a lower general survival rate but an overall increased life expectancy for those receiving hearts compared to their life expectancy if they hadn't got them. Maybe this explains the lower survival rate of American transplant recipients compared to Australia and Britain.

At first glance one could assume Australian transplanters were more skilled than the Americans. Anne Keogh of St Vincent's Hospital in Sydney implies Australian survival statistics are higher because of better after care service. Bob Spieldenner of UNOS jokingly says it would be unthinkable to an American that Australians could do a better job of transplanting. He has a point because Americans developed most transplant technology and are more advanced in the body parts industry. Even Christiaan Barnard went to the United States to develop his surgical skills before returning to South Africa.

But the politics of who gets the organs, so as to manipulate survival statistics, can be seen in the differing survival rates of Australia and the United States.

Also, both countries statistics are slightly inflated because patients who leave their country, or withdraw from treatment, are still considered alive regardless of their actual survival.

Survival Statistics

In 1997, prior to the suppression of Australian transplant survival statistics (except for kidneys), the heart transplant patient survival rate as published by the government agency, ACCORD, was 90% for the first year and 77% for five years. The US statistics published by UNOS in 1999 show a lower patient survival at 85% for the first year and 69% for five years.

Similarly, US liver transplant survival rates are 79% for one year and 63% for five years while the Australian were 83% for one year and 73% for five years.

The US pancreas patient survival rate is 96% for the first year and 82% for five years. In Australia it is 94% for one year and 87% for five years. The above is patient survival but the actual pancreas graft survival is another story. Graft survival is where the patient may survive but the transplanted organ fails or is rejected and must be cut out before it goes rotten. U.S. pancreas graft survival is 76% for one year and 35% for five years so you can understand why the Australians suppress graft survival figures. It doesn't fit in with their "life-saving" transplant sales theme they throw at grieving relatives in the waiting room and at the public through mass advertising campaigns.

Pancreas graft failure means the patient is back on insulin and the whole thing was a waste of time with increased suffering, expense and risk of death from surgery and drugs. There doesn't seem to be any proof that pancreas transplants increase life expectancy and, with the anti-rejection drugs and surgery, may actually reduce it.

The kidney statistics for 1999 from The Australia New Zealand Dialysis and Transplant Registry (ANZDATA), based in the Queen Elizabeth Hospital in Adelaide, indicate one-year kidney patient survival at 95% while the kidney or graft survival is 91%. Harvest promoters never fail to broadcast these encouragingly good figures. But these one-year figures are misleading in that they only include people receiving their first kidneys. Five year patient survival is 84% while 72% of kidneys kept functioning. [41a]

It isn't generally known, and harvest promoters visiting schools don't mention it to the students, but a considerable portion of harvested kidneys go to sick old people who are getting their second, third, fourth and even fifth transplants. Each succeeding graft has a lower functioning life than the previous. Instead of being cured many older patients need a continuous supply of other people's kidneys to avoid dialysis.

Like kidneys, corneal transplants don't save lives. They improve or regain a patient's eye sight and based on 1997 Australian figures have a 91% graft survival for one year and 74% for five years. Another interesting statistic kept suppressed is patient deaths and ill health from corneal transplants and immune-suppressant drugs.

Bone Marrow Donors

The survival of bone marrow recipients is suppressed because their survival rate is so low and this is from a disease that has a very slow kill rate. A person can be sick for many years before dying while the transplant survival rates suggest it actually reduces their lives and is still an experimental procedure.

The Surgical Procedure for Bone Marrow Replacement

Millions of potential donors are waiting to become living bone marrow donors. If chosen they are admitted to hospital for removal of approximately half a litre of bone marrow from their pelvic bones. It will entail staying in hospital a few days to recover and longer if infection develops from the needle pushing outer flesh into the bone itself.

The difficulty is finding a donor with the most identical marrow to the recipient who is usually suffering from leukaemia. Once a donor is found he or she signs on the dotted line agreeing to donate the marrow within one week.

Doctors then inject poison drugs and use radiation to kill the bone marrow inside the recipient patient's bones. The patient, now without living bone marrow, is doomed to death in one week unless the donor keeps his or her word. The donor now has the ability to become a murderer and get away with it. When the donor enters hospital the marrow is withdrawn and injected into the recipient. With the donor's marrow the victim lives on though the survival rate is low.

The problem is that the poison and radiation rarely kill all the bone marrow cancer and the surviving cancer cells spread to the donor marrow and the patient is back to square one.

Chapter 9

Body Parts and Business

Body Parts and Products

Organ transplant interests complain that vital organ donations haven't risen for the past ten years. This is true. Prospective customers aren't shooting or knifing each other as in the good old days. Car seat belts and breath testing have dented the flow of brain-injured candidates. Better neurosurgery for stroke victims is reducing this other prime source of donors.

The Hidden Industry

But there is a hidden industry for which statistics aren't publicly presented and the donation agencies feign surprise and anger when asked about it.

This is the market for completely dead donors whose hearts and everything else has stopped. They are called cardiac dead donors. They are really dead. Their vital organs aren't always used, often due to deterioration during the dying process, but their bodies still provide raw material for surgical activities ranging from heart valve replacements to cosmetic surgery.

The American body parts processing industry is far more advanced than the Australian but demand for our cosmetic and surgical techniques is on par with the American. This means our industry is fed by imported parts and products harvested from dead Americans. Our medical industry, through demand for cadaver products, encourages Americans to aggressively harvest their own citizens' bodies. In that way Australian users of imported body parts are also responsible for what Americans do.

Compulsory Harvest Requests

In 1998 Clinton Administration legislation forced United States hospitals that receive Medicare payments to pressure relatives of the deceased to sign voluntary harvesting consent forms. This increased cardiac dead harvesting in the United States 172% over five years to 20,000 bodies annually or three and a half times the number of vital organ donors. [42]

Worth More Dead Than Alive

This isn't a joke. The power of the American transplant industry to determine government legislation hinges on the fact that a single donor body can provide the raw material to generate products selling for US$220,000 wholesale.[43] When adding surgical fitting costs it can reach one million dollars. If the donor also supplied vital organs the amount generated by one body is two million dollars. Most of us are worth much more dead than alive. The Gift of Life more resembles a market commodity and a factor motivating aggressive transplant

coordinators to help meet market demand for dead bodies guarded by relatives who don't want their next of kin to be harvested. There is a higher demand than supply and this creates a hungry market. This explains why transplant interests so aggressively lobby governments, manipulate public opinion and fund donor promotion registries.[44]

Shortage of Skin for Burns but Plenty for Cosmetic Surgery

Harvested cadaver skin is used to cover holes left by tumours and make slings to support bladders of those with urinary incontinence thus alleviating the need for adult nappies. More skin comes from the obese and less from midgets and thin people. In the United States skin from one donor fetches $3600 if sold to hospitals to treat burns victims. Burns victims need layers of donated skin to protect the exposed and injured parts of their body from infections and to facilitate replacement of their own skin over the injured area.

Twenty thousand cardiac dead donors annually provide plentiful quantities of skin for medical purposes, but there is a continuous shortage. But in a free market society most of the donated skin is sold. Non-profit body harvesting Foundations receive the bodies for free then pass them on to cosmetic products companies for a token price. The processed skin for burns victims worth $3600 is transformed into cosmetic surgery products which eventually sell for $36,000 wholesale.[45] This artificial shortage means that burns victims don't get the cadaver skin. Instead their relatives undergo painful procedures with full anaesthetic where surgeons strip skin from their living bodies to be placed on their relatives' injuries while donated skin, painlessly removed from dead bodies, goes for cosmetic surgery.

Thick Frankenstein Penis'

LifeCell Corporation, using donated cadaver skin, produces Alloderm, a plastic surgery product used to reconstruct eyelids for older women who want to look younger and sexier. Other uses include reducing or enlarging breast size and thickening penises.

Have you ever wondered how movie stars or aging TV newsreaders have so few wrinkles or the women have such big, red pouting lips? Collagenesis, Incorporated of Massachusetts, uses cadaver skin to make an injectable gel called Dermalogen. Cosmetic surgeons will, for $1000 a shot, inject Dermalogen into the women to puff up their skin to remove wrinkles and laugh lines or fatten their lips. The benefit of Dermalogen is that the body doesn't break it down so repair jobs are less frequently needed. The drawback is with the permanency of injected cadaver skin. Ghastly mistakes are hard to fix.[46]

Alloderm and Dermalogen compete with similar products such as one cultured from the bugs living in the puffy fluid of arthritis sufferers. The "stuff" is injected into a person's (usually a woman) face to puff it up like arthritic fingers thus taking away the wrinkles. The puffy "stuff" is absorbed by the body and must be repeated at high expense every six to twelve months. Similarly, cowhides are made into a collagen and pumped into wrinkly faces. Another

product made from botulism paralyses facial muscles to stop natural facial movements that cause wrinkles.

Ever admired the thighs of scantily clad move stars? Fascia Biosystems of Beverly Hills, California sell a trademark thigh tissue to cosmetic surgeons. Fascia lata is the connective tissue holding thigh muscles together. Fascia is transplanted from the corpse to the movie star which may explain those incredibly firm and tight bodies.

Football and sports heroes don't miss out on the cannibal trade either. Ten of a corpse's tendons bring $20,000 (the Achilles and patella come with bone still attached). Knee cartilage is worth $14,000. When an Australian Football League player breaks a tendon or wrecks a knee he is off to the morgue for spare parts. A humerus fetches $28,000. Need a varicose vein job? Saphenous and Femoral veins, used for varicose vein and blood vessel reconstruction, sell for $14,000. Corneas, the clear part of the eye that covers the coloured part, fetch $2400 a pair. Heart valves are $7000 each from a heart costing Cryolife or other valve collectors less than $1000 from the non-profit Foundation, which they have usually set up as a front to obtain cheap or free corpses [47]

Bones and the Ladies Powder Room

We may think the blood and bone people dealing in human body parts are from a Jeffrey Dahmer style murder trial, but it is technology and market demand that has created the impetus for this industry. The market is hungry so the body parts industry relentlessly pressures governments for increased access to corpses.

The human body has 206 separate bones most of which will fetch a reasonable price, but it is at the processed, ready-to-transplant stage where the profits are to be made.

Bones are deep-frozen or freeze dried at 92 degrees below zero Fahrenheit. This allows storage of five years and helps reduce rejection. The first stages of bone harvesting is so simple that some American doctors take cadavers home and remove the bones in their garages.

Young donors with strong vibrant bones bring high prices while the porous bones of older woman are ground up for dental dust which gives a new twist to the term "ladies powder room". Harvesters want every human bone which indicates the challenge to morticians at open casket funerals and the delight of plastic medical pipe suppliers.

Dental Dust and Bone Putty

Small carpentry shops using only human bones grind out specially manufactured parts for hospital and dental surgeries. These include bone chips (looking like grated parmesan cheese), bone paste, screws made from bones, wedges, spears, blocks and a large range of custom made parts used to reconstruct, patch or replace the injuries suffered by living humans. Osteotech, Inc makes a bone putty costing US$853 for two teaspoons that is used to patch up small breaks. Larger

cracks are mended using a chip and putty blend. Demineralised human bone is ground into "dental dust" and used to improve healing after tooth extractions, spinal fusions and minor surgery. The "dust" is made by removing the 70% mineral content from bone leaving 30% collagen and non-collagenous proteins.

A dentist uses it after grinding out rotting teeth and jawbone. Dental dust is sprayed onto the exposed healthy bone to increase the healing rate.

It is also used when transplanting bone material from a corpse to a living patient. It helps to fuse the two bones together. It also fuses worn vertebrae and other joint bones to stop movement and associated pain. Dental dust's popularity hasn't suffered despite a problem with it transferring HIV-AIDS. This problem has reportedly been solved.

Business Links to Non-profit Foundations and Government Enterprises

One might wonder where business, donation agencies and hospitals merge in this creeping neo-cannibalism. Government hospitals are often reluctant players. Most doctors and nurses are dedicated to the Hippocratic ideal not to harm patients yet the act of cutting out a healthy (and it must be healthy) beating heart from an injured patient isn't exactly First Aid. Some wish organ harvesting had never been developed.

The organ procurement businesses have infiltrated their influence into medical establishments and may be pressuring next of kin within three or four hours of the patient being diagnosed brain dead – or even before this point. This is usually before the rest of their family have reached the hospital or even been told of the injury. The patient can even be harvested before some nearby relatives learn of the illness or injury.

Hospital staff may avoid skin and bone harvesting and a team from the euphemistically entitled Tissue Bank will arrive to dismantle the corpse. American Tissue Banks operate like the non-profit Musculoskeletal Foundation. It is the largest body procurer in the U.S.A. theoretically operating as a benevolent society but actually a front organisation specifically set-up in 1987 by Osteotech, Incorporated, to obtain bodies free of charge, then transfer them for a tiny price to Osteotech, who begin the process of turning each body into $220,000 worth of products. Virtually every American body procuring Benevolent Foundation is a secret agent for a private company.[48] The Musculoskeletal Transplant Foundation of the U.S.A. produces a catalogue listing 650 body parts products.

Australians use more subterfuge and hide their body parts businesses within government science and educational institutions, but the relationships are the same. One section of the institution acts as a non-profit organisation that lures in the donated corpses then passes them to a business ally, which is another section of the institution. The Donor Tissue Bank of Victoria discreetly operates as a business within Monash University and the South Australian Tissue Bank

operates under cover of the Institute of Medical and Veterinary Science in Adelaide. The New South Wales Bone Bank hides out at St George Hospital in Kogarah. Another Australian characteristic is that body parts are often removed under the guise of medical post-mortems unlike in the United States where relatives are directly approached to donate the body for parts and materials.

The common feature of both types of organisations in the United States and Australia is that participants at every level profit financially, except donors and heirs.

The intractiveness of our predicament is that we have a medical industry on which over 500 surgical procedures depend on human body parts and products. National governments fund a medical industry that depends on the consumption of its injured, dying and dead humans. While this method of medicine remains funded by taxes and government protection our wellbeing will remain dependent on a form of cannibalism that we euphemistically call “body parts recycling” or the “gift of life”.

Chapter 10

Coercion

Coercion and the Sales Pitch

The experience of producing this monograph has taught me that the least reliable sources for accurate transplant information are offices established by government and industry to promote organ donation. This is a polite way of saying the donation agencies won't tell the whole truth. They lack any faith that a balanced understanding will encourage people to sign up as organ donors. They prefer the used car salesman tactics of trickery and deceit to entice the person to register as a donor. They appear to believe that citizens knowing both positive and negative aspects of harvesting and transplanting would avoid registering as donors or consent to harvesting of next of kin. So like the Australian Kidney Foundation they play the Give and Let Live Fallacy.

Give and Let Live Fallacy

The Australian Kidney Foundation parks their caravans outside shopping centres throughout the country. They pretend to be offering free blood pressure tests and kidney health advice. I entered their caravan in Rundle Mall, Adelaide, and before I'd uttered a word a sales woman hit me with, "Do you want to be an organ donor". I said, uh, no. The atmosphere turned heavy enough to cut with a knife and the three staff suddenly clenched their mouths and stared at pieces of paper. I mentioned the blood pressure tests which one woman performed then, without indicating the result, returned to her piece of paper. Even under pressure she only muttered, "okay", and "more exercise". Their presence in the Mall was to obtain organ donors not to give preventative illness advice as claimed.

Their promotional slogan is "Give & Let Live", but kidney transplants rarely save lives. They change lifestyles. Dialysis is an unpleasant, unhealthy experience that does little except save lives. People rarely die from kidney failure and dialysis. The relatively high death rate among dialysis recipients is because many people, virtually on their deathbed with multiple organ failure, are dumped on dialysis for a few months before they die. These are different from healthy people suffering only kidney failure who won't die from this disease as long as they get dialysis. Many prefer it to a kidney transplant.

Tricky, Disrespectful Language

Kidney Foundation donor cards say, *"I request that after my death any part of my body be used in transplantation for the treatment of others."* Let us look at this language. The words, *"I request"* suggests the donor is asking a favour rather than making a generous response to the Foundation's call for help. *"After my death"* doesn't signify whether it is cardiac death with a cold, grey, stiff body or brain death where part of the brain remains alive, the heart continues to beat and the body remains soft and warm. Nowhere in the Australian Kidney Foundation promotion material is it explained the extent of harvesting and the phrase *"Any part of my body"* isn't limited to just the vital organs as Kidney Foundation material implies. It means absolutely anything. *"For the treatment of others"* doesn't mean *"Give & Let Live"* it means any treatment from a heart transplant to a nose job, sex change operation or changing breast size.

The Australian Kidney Foundation seeks consent for body parts removal before and not after the donors understand what they are agreeing to.

The Special Donor Card

The South Australian Organ Donation Agency (SAODA) in 2000 was distributing a leaflet they knew was false. It said over 3500 children and adults were currently awaiting a life saving transplant in Australia. They knew this was false because statistics published by the agency show that in July, 2000 only 2802 were waiting while the Victorian Donor Registry said just 2% were children.

And what of these lifesaving transplants? 1784 of the hopeful recipients were awaiting kidney transplants, where dialysis is exchanged for a transplant rather than a lifesaving procedure. Another 745 hopeful recipients were old people waiting for cornea transplants to improve their eyesight but not to save their lives. This left only 273 waiting for a "lifesaving" transplant, 87 of which were waiting for livers despite many having ruined them through alcoholism or Hepatitis C via dirty needles. 20% on the liver waiting list wanted second and third livers each of which has a higher failure rate than the previous.

This leaves 186 transplant hopefuls of whom 66 were waiting for a pancreas due to a diabetic condition often caused by unhealthy living and eating. Like kidney transplants pancreas grafts don't save lives but only alleviate the need for pig insulin. Graft survival rates average less than five years when the recipient will be demanding yet another pancreas.

This finally leaves 120 patients waiting for hearts and lungs of which 10% are on their second and third hearts. In any case, half the heart recipients will live longer if they don't get a transplant, as explained in Mario Deng's study of German heart recipients described elsewhere in this book. This ratio interpreted into the Australian figures mean that at least thirty of the heart recipients won't increase life expectancy with their so-called lifesaving transplant. This leaves perhaps only a hundred of those on the whole Australian transplant list whose lives will actually be saved by a transplant, and then we can ask, for how long and how good will their lives be?

One might also question the so-called shortage of harvestable livers in Australia. The Queensland government has been selling liver transplants, using Australian livers, to customers who fly in from Japan for the surgery.

The Japanese government pays for the transplant allowing the Princess Alexandra Hospital in Brisbane to maintain and improve its transplant skills, and make a small profit, without the government paying the costs via Medicare, which would be the case if the livers were transplanted into Australians.

Wendy Edmond, the Queensland Health Minister said, “There were actually spare livers for transplantation.” If this is true then one could reasonably question the extent of the shortage of livers in Australia or, perhaps, Australians were being denied transplants of available livers because it is more profitable to sell them to Japanese. [48a]

18,000 Lives Saved?

The leaflet goes on to say, "Transplantation is a unique treatment which has saved the lives of over 18,000 Australians." The truth is that 89% were kidney and cornea transplants and most of the other 11% died quite soon after surgery or within a few years from drug-induced cancer or organ rejection. For a tiny fraction of the total the "life saving" surgery temporarily extended their lives in a usually still sickened body but it wasn’t like pulling someone out of a raging river.

The leaflet avoids informing the donor and says organs are removed "when the brain function stops forever." The magic word is "function". Its use cleverly avoids acknowledging any definition of brain death. "When the brain function stops forever" means, in their language, the ability of the brain and brain stem to maintain all vital bodily processes is severely impaired.

So when they say "brain function stops forever" they mean some parts of the brain that control vital bodily processes are dead, injured or dormant. Though the condition they refer to as, "brain function stops forever" is usually terminal within a few days some parts are still alive and may include those responsible for higher consciousness. Simply put, the prospective donor is agreeing to allow harvesting to begin on their body while their heart is still beating and other functions continue with the possibility that some consciousness may still reside in their being.

How Much Harvesting?

The leaflet says as many as nine people will benefit from the organ or tissue donation from one person. The promoters uncharacteristically minimise the figure because telling the actual number would expose what the transplant industry may be planning for the donor’s body.

One Australian government source in 1996 said up to 32 people receive parts from a corpse.

The United States record is 422 with the average being over one hundred recipients per donor.

The promoters apparently designed the leaflet to attract religious people. A large, colourful picture on its front was filled with singing young people with upraised hands and closed eyes similar to Christian Revival meetings.

Donor Card Aimed At Children

The attached donor card, on the leaflet described above and distributed by the South Australian Organ Donation Agency, was aimed at children. The Gold Donor Card was designed like an ATM card with National Australia Bank emblazoned in large letters. Another emblem said "Donor Recipient Medical" despite the card being a donor card and not a recipient card.

The agreement to donate viscera, tendons, skin and organs said, *The holder of this Gold Donor Card understands and appreciates the value of becoming an organ donor and has discussed this decision with their family.* This innocuous language allows a child to pledge their body for organ harvesting without actually acknowledging it in writing. This disguises the fact that harvest promoters target children away from their parents. Promoters cover themselves saying children must have parents or next of kin consent because in Australia, and most other countries, hospital protocol allow parents or next of kin to veto harvesting regardless of a child's intent.

The promoter's plan is to hit shocked and distressed parents with the line of, "*your child would have wanted it."* Another reason for targeting children is to build up intending donor numbers for propaganda reasons as children have a low death rate and the donor industry wants every one they can get.

The Australian Transplant Awareness Association published the leaflet and donor card, but who are they. Karen Herbertt, Executive Director of the South Australian Organ Donation Agency that distributes their material, couldn't remember.

Media Collusion

The Organ Donor agencies don't mind the media falsely interpreting the transplant industry. Dr David Hill, writing in the book, *Beyond Brain Death,* cites an instance when a child he knew had liver problems with a life expectancy of one year. Transplanters gave him three liver transplants which all failed and he died that year. Despite the public expense and increased suffering of the child,

whose life was not extended, the media hailed the three failed transplants as a victory of modern science.

Sunday Mail

In the Adelaide Sunday Mail of 3 September 2000 Robyn Riley erroneously reported that "2000 Australians needed a life-saving organ transplant" As shown above most of those hopefuls are awaiting non-lifesaving grafts. Robyn also said "As many as 500 people died waiting." Some transplant hopefuls, mostly on dialysis or awaiting corneas, may die during the year but usually from old age, car smashes, and traumatic injuries or from causes that a transplant wouldn't have helped. But five hundred? Perhaps, if they joined a *Senior Citizens Awaiting Transplants Cruise*, the ship sank with no survivors, perhaps then, 500 could die on the waiting list, but not otherwise.

Choice Magazine

Choice Magazine analyses the quality of products and services and is published by the Australian Consumers Association They test items like washing machines for noise, water and power use, operating costs, purchase price, reliability and quality of wash. They also analyse products like those tricky mobile phone contracts.

The August 2000 Choice ran an organ donation feature which included deaths on the waiting list, happy transplant stories, how to register for donation and addresses of donation agencies. Choice used euphemistic language describing skin, bone, ligaments, tendons and fascia destined for harvesting as "tissue" which sounds like Kleenex or gift wrap rather than the smelly blood and guts material it is. Choice erroneously claimed kidney harvesting requires a beating heart which is proven untrue by current Japanese kidney transplanting practices.

In their article Choice diverted from their usual product and service analysis by avoiding the negative aspects of transplant technology. They neglected mention of the controversy of brain death diagnosis, that donors are paralysed and often anaesthetised before harvesting, that anti-rejection drugs cause AIDS-like immune deficiency diseases or that kidney transplants rarely save lives. The above could be forgiven since research in this field is difficult, expensive and time consuming. But what can't be forgiven is that Choice didn't say that Australian survival statistics are suppressed. They knew this because they had to use United States statistics.

Choice staff wrote the article to cloud readers' understanding of transplanting not to inform them.

Time Magazine

You would expect Time Magazine with its vast resources to do better than Choice but they are similarly mesmerised by the technology and appear unable to provide an informative and balanced report.

The Time Australia edition of February 26, 2001[51] contained an article titled *"Life Out Of Death"* by Leora Moldofsky in which the same dreamland myths were propagated without question. Ms Moldofsky reported that Graeme Spencer of Canberra was waiting for a kidney and pancreas transplant then mourns in the following paragraph that "Spencer has a 5% chance of dying before suitable kidneys become available" Graeme Spencer wanted one kidney and a pancreas, and the waiting time for a kidney alone is one to three years in Australia (Australians Donate May, 1999). After receiving these organs his chance of dying during the first year is 5.5%, according to American statistics from the United Network for Organ Sharing (UNOS), which is a higher death rate than if he missed out. So what are Time Magazine and Leora Moldofsky mourning about?

A statement by Graeme that, "There's always hope I'll be cured but it's so frustrating that it hasn't yet happened" goes unchecked by Time. Most medical experts will say a transplant is not a cure. It is exchanging one medical condition for another. The US rejection rate of a pancreas/kidney transplant for one year is 17.4%* for the pancreas and 8.6%* for the kidney so Graeme certainly won't be cured. His body will probably kill the pancreas within five years and he will want another one requiring further dangerous surgery.

*(March 2001 figures from United Network for Organ Sharing, USA. Australian survival/death statistics currently suppressed)

The article also says "…a single organ donor can save up to nine lives". How? Has any donor ever saved up to nine lives? For how long?

Time magazines uses tricky journalism where emotion-stirring life and death examples are recounted to trigger our compassion. Then it states that 2000 are on the waiting list neglecting to note that most of the 2000 are waiting for corneas to improve or regain eyesight or for kidney transplants.

Chapter 11

Australian Transplant Legislation

The South Australian Transplantation and Anatomy Act of 1983 is fairly typical of other Australian State legislation. It allows a government bureaucrat to order removal of the organs, bones and tendons of donor card signers regardless of next of kin wishes.

Even if the patient hasn't signed a donor card or registered an objection to donation then the bureaucrat can still order harvesting if the relatives aren't objecting or can't be contacted within a "reasonable period".

Bones, skin and body parts can be used for scientific and medical purposes, non-coronial post-mortems (which in some states has been a time to secretly remove organs) and for the study and teaching of anatomy if the person hadn't registered an objection nor do next of kin object.

Harvesters may legally seek and obtain next of kin consent not only when the injured patient is brain stem or brain dead, but merely unconscious and uncommunicable, prior to an expected brain death. Obtaining an early consent signals to transplant and other hospital staff that it is safer to declare brain death, as there won't be objections from relatives. The sooner brain death is diagnosed the sooner the brain damaging organ stabilisation process can begin. (If it hasn't already begun).

Next of kin means the patient's closest relative. Wife, husband or partner are closest. Next closest are adult children who are classed as closer kin than parents. A cynic could say children are classed closer than parents as older people are more reluctant to consent to harvesting of their children.

Registering as a donor allows the transplant coordinator to order harvesting despite objections from relatives though for political reasons this isn't applied in Australia and harvesting still depends on consent from next of kin. The worst nightmare of harvesters isn't making a surgical error. It is an angry relative going to the media with a ghoulish story.

Who Is Chosen To Obtain The Brain Death Determination?

Either the legislation or hospital protocols (their internal rules) will require brain death diagnosis to be made twice by two doctors not involved in harvesting or transplanting of that person's body parts. This safeguards against a harvester wrongly diagnosing brain death just to grab some organs for his patient. Dr Juro Wada was accused of this in Japan and charged with double murder, once for harvesting the patient's heart and, secondly, for the recipient who got a heart he didn't need and died.

Transplant surgeons know how to get around the problem of getting a declaration of brain death.

Getting Around “The Problem”

Dr David Hill, the English anaesthetist mentioned elsewhere in this book, says the United Kingdom pattern is that doctors reluctant to make quick brain death diagnosis won’t be asked to conduct the tests,

> "…doctors who are sympathetic to this form of death are required and consequently others, such as myself, who would not certify death on the basis of such tests, are not asked. It is doubtful whether this situation would pass any serious scrutiny for being truly independent of the transplant team." [49]

The ease of getting a declaration of brain death depends on the integrity and desperation of the hospital. The transplant faction will want a quick brain death certification while the other faction will hesitate, even covertly delay the determination.

Another Implication of Being An Intending Donor

Registering as a donor has implications determining how your body is used for other purposes. As stated above most legislation gives a medical bureaucrat the right to order harvesting if there isn’t a record of your objection and next of kin can’t be contacted. This applies also to medical testing and anatomy classes. Few people ever make a point of saying they won’t allow their body to be used for these purposes because who actually gives it any thought. A wary bureaucrat may be reluctant to order a non-donor’s cardiac dead body for such purposes but being a registered organ donor makes it easier to assume the person wouldn’t have objected. They may also say to your relatives that you wouldn’t object to the hospital or medical school using your completely dead body for teaching dedicated students life-saving techniques for later use on living people. They may also throw in their standard script, "Let us make the best of this tragic occurrence. Your son/daughter would have wanted it this way."

What they won’t say is that it may involve practising cosmetic surgery or that parts of your body may be covertly stored in jars for decades. The research institution may take over the burial of your remains not out of kindness but so they keep control of the body and stop you seeing the mess they made. Though to be realistic, the human body quickly becomes a decomposing mess regardless.

Chapter 12

Avoiding Harvest Time

Transplant Coordinators Won't Accept A "Soft No".

As stated above the hospital can legally remove organs and bones from a registered donor without next of kin consent. They won't because societal consensus doesn't hold that organ harvesting is wholly beneficial, or that the donors are completely dead, and harvesters don't dare risk nasty reactions from next of kin. But medical technology increasingly requires more body parts and the industry players have become increasingly desperate to harvest and transplant more organs. Their representatives, such as Professor Geoffrey Dahlenburg of the South Australia Organ Donation Agency, say that a "soft no" by relatives isn't good enough. There has to be an undefined "strong objection" after some discussion between shocked relatives and desperate transplant coordinators in the hospital waiting room or wherever.

Delivering The Hard Word

The transplant coordinator or, intensive care staff, will sidle up to the relatives in the waiting room and begin the sales pitch by expressing sympathy and hinting that good may come out of this tragedy. If the patient isn't dead the coordinator will leave and pressure hospital staff to get an apnoea and brain death test confirmation. If this happens preservation of organs may begin which may accelerate brain death.

The coordinator will later return continuing with the stream of ideas saying the positive outcome of lives saved from donation can result from the terrible negative of impending death. If the dying or seriously injured patient registered as a donor the coordinator may mention the hospital isn't legally required to obtain consent but are doing it from kindness. This ploy is to undermine the relatives' confidence in their legal status and position the coordinator as a benevolent and kind person. It is a bluff.

Transplant Coordinators May Try To Position Themselves Between The Injured Patient and Relatives

Transplant coordinating staff, especially when they are the intensive care staff, become the teller of the prospective donor's condition so relatives depend on their messages and feel they must repay something for this kindness. The coordinator may imply a closer and more intimate access to the patient than that of the relatives. They may try to mentally inveigle themselves between you and your dying relative. They may imply the patients' dignity and comfort depends on you keeping them happy by agreeing to donation. If the patient wasn't a registered donor they may attempt to extract a statement from you that the patient had expressed a favourable opinion of organ donation or at least didn't express objections to it. This will give them a legal standpoint that the patient would not

object to donating his or her organs and again, that seeking family approval is only a kindness on their part and not a legal requirement. The transplant coordinator will apply as much pressure as can be gotten away with. This will be disguised under the cover of caring emotions and kind thoughts, but the underlying motive is getting the organs and perhaps the whole body. It should be remembered that the coordinator and transplant staff are extremely desperate people. Relatives may experience their sales pitch as an unpleasant seduction attempt and subconsciously know there is an underlying motive.

Nurses may become involved and tell the harvest promoter to go easy. One faction in hospitals follows the Hippocratic oath of protecting and nurturing all injured patients while the other faction wants to help one group of patients by cutting up those predicted to die and using them as spare parts.

Harvesters Mistrust Other Hospital Staff

The position of Transplant Coordinator was invented in the United States after industry promoters discovered Intensive Care Unit staff were reluctant to pressure relatives to consent to harvesting. Experts in the United States discovered the problem of low donation numbers due, not so much to public resistance, but with intensive care staff who wouldn't ask relatives. It was even said some nurses and doctors disguised patient conditions from the harvesters.

In Australia it is usually intensive care staff that seek consent to harvest.

Repelling A Transplant Coordinator

Anyone can repel harvester coordinators by threatening to hit them. A physically weak person can do this because the harvest coordinator wouldn't dare be seen beating up a relative in the hospital waiting room while attempting to extract consent. Another tactic is by walking about the hospital telling patients and staff that the harvesters want to cut up your still breathing relative for spare parts. This desperate act would have a strong impact in making the transplant coordinators back off. A second defensive action is to keep moving about. One should move the body and limbs while sitting, even walking about the building, anything to avoid the hypnotic stare of the harvest coordinators. This will help protect you because your emotions and brain will be in shock and you may be vulnerable to the harvesters' mesmerising voice and presence. Sitting still is like being a hypnotic subject. A third defensive action is calling the media. Newspapers and television stations feed on Frankenstein stories and you will be in the middle of a national story. The least effective tactic is intellectual argument. Transplant coordinators are desperate for victory and won't hear a word you say. They are immune to argument.

Anecdotal evidence from the industry reports that cases of relatives refusing to allow harvesting are increasing. Nora Machado in her book, *Using the Bodies of the Dead* reports a 40% refusal rate in Sweden and 30% in United States.

Kerridge, Saul, Lowe, McPhee and Williams report in their paper in the Journal of Medical Ethics 2002; 28: 89-94, a "refusal rate" (by families of potential

donors) of 82% in 1999 in the Australian State of New South Wales - up from 56% in 1995.

Bruce Lindsay of Australians Donate reports a refusal rate of "nearly 50%…" This last figure was in a letter Bruce sent thanking me for my interest in becoming an organ donor. Actually, I had asked how to register as an organ keeper.

Protecting The Patient

Head injury patients may increase their recovery chances if their relatives insist, with witnesses present, that neither the apnoea test be applied or any treatment designed to preserve organs for harvest. Stating the patient won't be a donor and had recently expressed distaste for donation will reduce interest from harvest staff and transplant coordinators. You could also suggest that hypothermia and use of brain cell protecting drugs, such as barbiturates, be used as treatment if applicable.

You can also insist on visiting the patient in privacy without medical observation. If allowing the dangerous apnoea test you could still insist on observing the procedure. You may also insist it not be performed. The reflex test is shocking because the doctor inflicts pain to prompt response. You could also require that two flat EEGs be obtained and brain death not declared unless there is a blood pressure collapse.

Death Vigil

Elephants, hippopotami and other less evolved animals protect dying members of their species from predators until they are completely dead. Only when all life has left the animal and decomposition sets in do they abandon further vigil. We should also protect our next of kin and, sadly, it is from our own species.

It is often the organ harvesters who control the registration system making it difficult and unreliable to effectively register an organkeeper or organ retainer decision. We are bombarded with appeals and means to register a decision to allow harvesting, but the mechanism to centrally register an organkeeper decision rarely exists. More sinister is the subtle propagation of the concept that our individual bodies are owned by the species as a whole and not by ourselves – an apparently benevolent concept until one investigates who control the medical industry and their motives for promoting this concept.

Who Owns A Dead Body?

A patient declared brain dead with a beating heart hasn't any legal rights. This means most of the patient's previous directives on treating their body are not legally binding. Some states have Power of Attorney or Advance Medical Directives where you can give advance medical treatment orders before death. This includes the point of deterioration where you no longer want medical treatment except pain reduction. The contrived brain death criteria erase these orders because you're legally dead and Advance Medical Directives only cover a

living person. The fact that part of your brain is alive and your body quite alive make no difference.

At this point closest friends or relatives face difficulties in directing treatment because you are dead or, so the medical authorities will say. Certain conditions for treating the body can be left in a will but it will be days until this is read. Until then the brain dead patient in a hospital is quite at the mercy of staff who may want to harvest parts while the patient is still warm, pliable and with a strong blood circulation.

Protecting Your Body

The legal key to protecting yourself, and later your body from harvesting, is by ensuring that numerous people know you are an organ keeper. Once your legal advocates and donation agencies know you require an intact body for burial or cremation they are legally obliged to ensure it stays that way. This will legally protect you and your body, a fact that angers the donation agencies, who respond by making it very difficult to register the choice of "no harvesting, thanks".

The Australian Organ Donor Register is the computer data base available nationally to medical and transplant promoters. It is designed to easier identify patients who acquiesce to organ and body parts removal. Medical and transplant staff around Australia can check patient names with the Register and record this detail on the patients' hospital record so staff can identify each patient as a donor or organkeeper right from the start. The startling feature of its on-line registration is that a person can register an organkeeper choice. While this is an encouraging development one cannot by all means be assured that the register won't be changed before or on "harvest day". The problem for organ keepers is that the on-line form is for donors. One must fill in the whole donor form, giving medicare card number and personal details as if one is an organ donor, then tick a tiny box that indicates organ retainer. This leaves it very easy for a harvest agent to change that single box to make you a registered harvest candidate.

A much safer system would be having two separate databases with separate staff. An organ keeper would complete an organ keeper on-line form and a harvest candidate would fill out a separate donor form.

The Australian Organ Donor Register's paper application is even worse. To register an organ retainer decision staff insist the person complete a whole organ donation form agreeing to donate organs including ticking a specific box saying you want to an organ donor. Then, Register staff suggest without a trace of embarrassment, one lists on two tiny lines all the organs, body parts and substances you want to keep. Simple as that, providing you know all the body materials the harvesters want, and you want to keep, and can list them in tiny, tiny print on two tiny lines.

Even donors could be deceived into thinking they were registering to donate their heart, liver and kidneys (called "mixed grill" in the industry), and perhaps say, "leave my eyes" but unwittingly signing over their remaining body.

Quite probably many people would be signing up for a degree of harvesting while thinking they had protected themselves.

Like on-line registration there should be a separate paper form for organ retainers and even donor registration forms should have a checklist of all harvestable organs, body parts and other materials. This would allow prospective donors an "informed consent".

The Register avoids this because it would shock prospective donors, especially children, with the extent of body parts harvesting and expose the unpleasant fact that very little harvesting involves lifesaving surgery. But the Register, like all those the world over, won't and can't because a population informed on the subject would rush to cancel donation and become organ retainers.

Such deceptive methods restricting an informed choice don't inspire trust. If governments do this at the propaganda and bureaucratic level, while we are alive, one can only imagine what happens to the brain-injured human, lying on the harvest table, and when relatives have been excluded.

Organ Retainer and Organ Keeping Cards

The Australian Organ Donor Register is one of the few databases in the world that will register an organkeeper decision. But computers crash and data can be manipulated. In the coercive environment of organ transplanting you may benefit by carrying an organ retainer or organ keeper card.

Carrying a card signifying your intention to keep organs and body parts intact before and after death will generally be respected by hospitals. It will help to keep multiple cards, one in your wallet with Medicare or health insurance cards and others scattered throughout your worldly possessions. You can state your organ keeper intentions and, though this isn't necessary, get a witness to sign your card. Homemade cards are valid or you can list your preferences using prepared cards from any country in the world. Your stated intention in writing is the significant factor rather than who prints the card. A card signifies your intentions so either a homemade card or any statement in writing is applicable in any country.

Australian and World Organ Retainer Cards

These simple cards are available from www.geocities.com/organdonate or www.geocities.com/organretainer. Files in Word will be emailed on request or you can print directly from the site.

Japanese Organ Keeper and Organ Donor Cards

The Japanese Organ Transplant Network distributes free cards in English or Japanese. Their unique card has three levels of intention, brain death donation, cardiac death (complete death) donation or "I do not want to donate". Most

Japanese find organ harvesting a repulsive and spiritually dangerous concept thus three choices was the most intrusive their transplant industry could pressure the government to legislate for. It is important to circle your choice with a scratch and then ink over the scratch. The other choices could be scratched out to avoid changes by pro-harvest medical staff. Their cards have only a section for a signature so scratching your name and inking it over seems preferable to depending solely on a signature. You can add more precise instructions by attaching a piece of card or paper to the official card. These free cards can be ordered by email from their website, www.jotnw.or.jp.

Organ Keeper CardsTM_{50}

Duane Horton, an engineer and entrepreneur, of Rhode Island, USA operates www.organkeeper.com, a website promoting increased organ transplanting through payments to donors and their families. Duane says organ donating would increase if the rights of organ donors were improved and encourages prospective donors to go on strike until governments improve conditions. Duane Horton is the western world's leading donor rights activist.

Duane publishes a detailed, absorbent surfaced, trade marked OrganKeeper card that signifies the holder wants to retain organs upon brain death and complete death. There are six tickable boxes each giving a reason why the signer is opposed to organ donation. These are:

1) Laws prohibit compensating surviving family of donors;

2) Those who register as donors should get preference if they need an organ;

3) Organs and body parts may go to people the donor dislikes. (the card has space to list the people. E.g. used car sellers, drug dealers, next door neighbours, etc.);

4) Harvesting violates religious or moral beliefs;

5) It is wrong that doctors, hospitals and pharmaceutical firms derive huge profits from *donated* organs and tissues.

A last section is blank so you can add your own reasons. Duane may post the cards for free if you send him a self-addressed, stamped envelope or you can print cards from his website, www.organkeeper.com.

The benefit of Organ keeper and Organ Retainer Cards is that the signer retains control of the printed information and may duplicate it for protection. Those who sign as organ retainers with an electronic register, such as the Australian Organ Donor Register, cede control of this statement to pro-transplant bureaucrats.

Power of Attorney and Tattoos

Giving Power of Attorney to a person chosen by yourself protects your body from transplant harvesters. Power of Attorney allows your representative to represent your interests as directed by yourself when you were conscious. You should have a note on your person naming your representative.

Tattoos are a permanent form of registering your intention to be an organkeeper. A harvesting surgeon might be reluctant to slit up the torso of someone with Organ Keeper tattooed in big letters across his or her body. Just make sure you don't change your mind.

Organ Keeper Cards are an anti-dote to Donor Cards, the latter perhaps signed without thought, and in the midst of a promotional talk by harvest promoters. Dated organkeeper cards can also counteract your having signed a donor card or an electronic register then forgotten and later changed one's mind. Donor Cards are often signed without too much thought but they are serious documents that have serious ramifications. Dr David Hill has observed,

> "People may well sign out of commendable altruism but in complete ignorance, but this Card [Donor Card] has legal force and the status of an advanced directive."

Chapter 13

Societal Consensus and the Slippery Slope

One could easily doubt the validity of criticising transplant coordinators who so considerately wait for next of kin consent before allowing surgeons to harvest organs from registered donors. After all, they aren't legally required to.

But the reason for their sensitivity is their acute awareness of what political scientists call societal consensus. This means promoters know many people are innately disgusted by transplanting and don't want to upset them.

Parliaments and legislative assemblies easily passed harvest legislation with little organised objection because few understood the processes except the advertised idea of dead bodies being used to save beautiful peoples' lives.

Then came the reality. It began when nurses and doctors, after observing the reduced care for donor candidates, began privately advising their friends to avoid signing donor cards. Then some high level surgeons and specialists withdrew in disgust from positions involving transplant procedures.

Legislators may pass unpopular laws with ease but it is the enforcement that prompts civil reaction. Before enforcing new laws a government needs a significant proportion of the population in favour otherwise it risks spontaneous and then organised resistance or civil unrest. There could be demonstrations and sabotage resulting in police beating citizens and courts clogged with objectors. Rival politicians might then exploit the confusion and pledge to repeal the law at the next election.

To avoid these reactions an astute government uses the "frog in boiling water" procedure. When a frog is thrown it into a pot of boiling water the sudden pain prompts it to jump out and escape. When dropped into warm water it swims around and relaxes. When the heat is slowly increased the rising water temperature lulls the frog into a pleasant lethargy. Then when the temperature begins to kill the frog it is too dazed and sleepy to jump out. It then dies.

To avoid negative reaction to transplant legislation the astute government orders its bureaucracies to gradually promote and introduce harvesting laws as good and voluntary acts rather than being obligatory and enforceable with penalties. It runs "awareness" campaigns, like the Australian Organ Donor Register and "Australians Donate", who hired models, professional actors and a stand-up comedian to promote "awareness". These paid actors pretend they love being donors despite the fact that real donors are never able to return to say how good it was. Media kits include photographs and video clips of smiling children with organ transplants and "donor" relatives saying how wonderful they feel about donating the heart-beating bodies of their "dead" children.

*The Australians Donate organisation got a little surprise when they hired the actors for what they thought was a single payment for a series of sessions. They later discovered a small clause in the contract requiring them to pay each actor per media exposure meaning they have an ongoing financial commitment. The actors are laughing.

These promotion campaigns are run by advertising promoters who are increasingly replacing medical staff to promote harvesting and transplanting. These promoters are hired to visit schools to increase "awareness" and are trained as advertisers to carefully avoid telling children the negative aspects of being a donor.

Ghost Organisations

Governments and pharmaceutical companies have another trick. They provide lavish funds to a few ambitious individuals in the industry who form a loose "association" giving themselves a name that suggests a mass movement. This small group produces car stickers, pencils, stationary, badges and T-shirts all promoting the government's view. Once the items are printed and a media release issued the "association" may never meet again. The promotional material is distributed for years in government departments and non-government agencies. Their aim is to lull the public into feeling there is a huge undercurrent of sentiment thinking favourably of transplant medicine so it must be good, but it is just a government and drug company advertising campaign.

When a societal consensus is formed with the majority or, at least a significant minority favouring the government view, the bureaucracies gradually enforce the harsher aspects of the law. Volunteer behaviour becomes compulsory behaviour where dissidents or resistors are branded as deviants or extremists.

But until this societal consensus is formed transplant coordinators will display consideration despite a law that allows hospitals to harvest donor card signers without seeking next of kin consent. If this consensus is formed then even those wishing to die intact, but who haven't registered the difficult "no" choice, may be legally harvested if they don't have an organkeeper card or advocate to indicate otherwise.

Desperation in the Body Parts Industry

Medical technology allows surgeons to perform acts of incredible benevolence to patients but this technology has created an industry that manifests, metaphorically, as a "hungry animal" requiring ever increasing portions of dead and semi-dead human beings.

Exponentially increasing technological advances keeps more and more sick people alive. Governments are no longer willing or able to pay the costs of drugs and medical equipment. We can't kill the sick or let them die when the medical technology is available.

Organ transplants, particularly kidney and cornea, are a stopgap answer. They are cheaper to insert than paying dialysis or home care. A government decision to promote transplantation has increased demand for fresh organs.

On the supply side of the equation, raw materials, in this case body parts, aren't keeping up with demand. Car smashes are producing less brain-injured bodies while the treatment of brain injuries, including strokes, are improving. Young men, in particular, have become less enthusiastic to beat each other around the head thus denying the harvesters another source of live organs.

Even prospective donors have become fussy and rarely say, "take all" but are limiting harvesters to the "mixed grill" (heart, kidney and liver) or just a single organ. Next of kin are also playing harder to get with the harvest coordinators. Supply is not rising to meet demand so governments are pushing harder and harder to increase or just maintain supplies of vital organs.

More Pressure on Relatives

So it shouldn't be any surprise when Professor Geoffrey Dahlenburg of the South Australian Organ Donation Agency says transplant coordinators will no longer be accepting a "soft no" from relatives. The new requirement will be "strong objection" after some discussion. He says transplant coordinators "need to know" the reason why next of kin won't consent to harvesting of their children or parents. Professor Dahlenburg faces a problem here. If coordinators pressure too hard then relatives will begin asking under what legislative or administrative rules the "requesting" is being done. The Professor walks a tightrope.

Geoffrey Dahlenburg (not to be confused with Jeffrey Dahmer, the American who murdered young men, chopped them up, put the parts in his freezer and later thawed them out to eat), is under pressure from the government to increase the supply of body parts. He must pressure transplant coordinators and other "requesting" staff to demand from shocked and dazed relatives to what in any culture must be a barbarous request.

The Next Stage of "Consent"

The next increment of pressure to obtain your body is called the "opt out" system where governments legally assume ownership of every person's body unless they register an objection in writing. This is not law in the U.S.A., United Kingdom or Australia, but Greg Armstrong of the Australasian Transplant Coordinators Association euphemistically sums up the industry's attitude with,

"We really need to consider presumed consent because if organ donation is legally sanctioned, theologically correct and ethically supported, why must people have to take action themselves to donate."[51]

There are two reasons why "opt-out" isn't universally adopted. The first is that Anglo-Saxon dominated countries have a sense of bodily self-ownership and distrust government claims of ownership. Secondly, governments that have adopted the "opt out" system have prompted a rush to register organkeeper decisions by their citizens who normally wouldn't consider it. Brazil chose "opt-out" but it backfired when people rushed to register the preference to keep their organs. One Brazilian summed up their attitude,

"Now we are doubly afraid of being hit by a car. We were always afraid of crazy drivers. Now we have to worry about ambulance workers who may be paid on the side to declare us "dead" before our time is really up."[52]

Spain and United States have the highest per capita rates of organ donation. Spain has presumed consent where the government legally assumes the right to remove body parts unless a citizen registers an organkeeper decision. In practice they still use the soft touch and seek consent from relatives. The United States, like most Anglo-Saxon and Celtic dominated countries, has an opt-in system where consent is sought from relatives and, usually, only if the terminally injured patients are registered organ donors. Other opt-in countries are New Zealand, Australia, Canada and the United Kingdom. Germany, Japan, Ireland and The Netherlands also seek consent from relatives.

Organ Donation Around The World

Japan has, perhaps more than any other technologically advanced country, the strictest rules limiting organ harvesting. The prospective donor must be over fifteen years of age and express in writing a wish to donate organs either, after brain death or, after complete or cardiac death. Relatives must also consent after the donor's "death". Kidneys may be removed without the donor expressing a wish for it if the family agrees, but only after complete death when the heart has stopped. This differs from most countries where kidneys from cardiac dead donors aren't used.

Portugal, Luxembourg, Italy and Greece have presumed consent or "opt-out" systems but, like Spain, seek next of kin consent.

Hungary, France, Finland, Denmark, Cyprus, Bulgaria, Belgium, Austria, Sweden and parts of Switzerland have harsher attitudes and apply presumed consent. They automatically remove organs and body parts from "brain dead" and cardiac dead donors without requesting consent or even advising next of kin. Harvest surgeons in France sought consent from the father when they cut off the right hand of his nineteen-year old "brain dead" son to sew onto Clint Hallam. They weren't required to but with international media focused on the world's first hand transplant, it was a public relations gesture and insurance policy if the father later became disillusioned.

Austria, Denmark, Poland, part of Switzerland and Latvia are the fastest countries to remove organs without consent or notice. International travellers with dual citizenship visiting these countries should carry organkeeper cards, advise relatives and write "organkeeper, no body harvesting" onto all their documents. It should also be noted that countries often apply their harvesting laws to international tourists, but generally one could say that any indication of an organ keeper choice will stop them from removing organs prior to complete brain/heart death.

"Softly, softly" Increases Harvesting

European countries that adopted and applied presumed consent found their harvest rates lower than Spain and the United States that seek next of kin consent. Governments presuming ownership of citizens' bodies triggered a response similar to the Brazilian organ retainer reaction.

However, both "opt-in" or "opt-out" organ transplant programs are geared to increase supply through indoctrination and compulsion rather than increased understanding. Harvesting strategists know that many donors and relatives would avoid donation if they knew what it involved.

Except for China where prisoners are made "brain dead" by being shot on demand to satisfy rich, "hungry customers" with their organs, the United Kingdom is perhaps the quickest to declare brain death. The clever British have increased harvest production by lowering the requirement of brain injury to declare brain death. They assume that serious brain-stem malfunction is brain death. To avoid debating the meaning of brain death these deviously clever people have re-labelled it as "Certified Dead". Certified dead means the doctor says so. This change arose when they found that both lay-people and medical experts were convinced that many donors weren't brain dead or brain stem dead, but still alive and in a state that merely predicted death.

Chapter 14

Language Use And Gender Donor Rate

Like all trades and professions transplant promoters develop their own language to mask aspects of their business they don't want outsiders to know. Here is a small sample.

Transplant Industry Description	**General Public Language Use**
Smoked Herring ……	cadaver soaked in formaldehyde
Mixed grill…….	harvesting of kidneys, liver and heart
Retrieve organ……..	harvest, cut out, excise, extract organ
Heart-Beating Cadaver……	brain injured human predicted to die and classed as "brain dead"
Tissue …….	bone, tendons, muscle, fascia, intestines
De coupling……	relatives consenting to harvesting and agreeing that the brain-injured person with the beating heart is dead.
Transplant Awareness……	1)name of the transplant industry's public indoctrination program. 2) accepting the transplant industries beliefs and not asking questions
Brain Dead……..	1) brain dead 2) part of the brain is dead, part functioning and part dormant
"to offer families the opportunity to make their own decision about donation" ……...	pressuring relatives to allow harvesting
We need to know……..	We demand to know

Reduced Status of Intending Donors

The body parts industry had to develop a new language to disguise the fact they were cutting up and killing patients who still showed signs of life. It was a question of reducing the donor patients' status to heart-beating cadaver much sooner than is the case for non-donor patients retaining their organs upon death.

When an organ-retaining patient dies hospital staff treat that patient's body with continued respect first designating it as the deceased. As the cooling body becomes less human and loosens its bowels it is called a corpse. When the stiffness of rigor mortis sets in the status is reduced to cadaver, something quite and absolutely dead.

The status of a dying organ donor descends much quicker. Despite the patient making what is perhaps a magnificent final gesture, surgeons and transplant coordinators label the organ donor as the "heart-beating cadaver" immediately brain death is declared. This "cadaver" status is used despite the body staying warm, soft, pink, moist, and retaining a beating heart and, frequently, some brain activity and function.

If the "brain dead" donor was an organ retainer he or she would still be treated as alive and washed, fed and talked to by nurses and doctors. When surgical staff have to excise a beating heart they have to pretend, for their own psychological well being, that the patient is stone cold dead.

Refusal To Differentiate Between Cardiac Dead and Brain Dead Donors

Donor Promotion Agencies sensed the danger of people differentiating between "cardiac dead" donors and "brain dead" donors. They couldn't let people see the difference between the conditions because one would obviously seem less dead than the other. So they adopted the term "Dead Donor" meaning both cardiac dead and "brain dead". They then restricted the term, "Living Donor", to those walking around and expected to remain alive after the donation. This was to prevent the obvious becoming apparent – if a totally dead person was the same as a brain dead person then why was there such a huge difference between the two?

The criteria for determining brain death have become secondary to who wants the body and for what purpose. When the patient's body is wanted by harvesters they adopt a descending logic that goes like this: Loss of function = loss of ability to function = brain dead = really dead. In mathematics this illogic would appear like 4=3=2=1.

In determining this descent, "Doctor's Orders" no longer refer to "staying in bed and drinking plenty of fluid", but that the patient is dead because the doctor certifies the patient as dead. Doctor's Orders determine if the donor still has human rights or will be treated as a "cadaver".

Allograft in USA means Homograft in Australia meaning the body part is from Homo sapiens. The term Homograft is not used in the United States because Americans call gays "homos" and this might put people off

Below is a table showing the male/female ratio of brain-dead donors.

Gender Donors		
Country	Males	Females
Spain	67%	33%
Australia/New Zealand	61%	39%
USA	60%	40%
Sweden	59%	41%

Chapter 15

Getting A Transplant

Most transplant hopefuls won't admit it but they feel a peculiar tenseness on public holidays like Easter and Christmas. The sound of ambulance sirens on these days send bursts of hopeful energy through their body. Their success depends on a young man, usually a man, suffering catastrophic brain injury that doesn't kill him and leaves the body relatively unscathed.

Who Reaches The Waiting List?

Achieving the waiting list requires a fine balancing act between dire illness and strong health. The patient must have one or two failing vital organs but still healthy enough to survive until an organ is available then surgery and immune-suppressant illnesses. For instance, a patient may need a heart transplant but also having a bad liver throws doubts on getting the heart. This is because the main anti-rejection drug, cyclosporin, damages the liver and to withstand cyclosporin one needs a strong, clean liver to begin with.

Infections and Fat are Bad

Those with infectious illnesses or controlled cancers are excluded because most pre-transplant illnesses will run rampant when anti-rejection drugs suppress the immune system. Being fat is another exclusion factor as the drugs cause huge increases in weight that the transplanted organs may be unable to maintain. Surgeons prefer transplanting into naturally thin or medium build people who often become fat after the surgery.

Organ Recipients Can't Have Psychotic or Depressive Tendencies

Mental stability is crucial because transplant recipients often become psychotic, bi-polar or depressive. The shock of surgery, the drugs, chronic wound pain and faulty transplant organ are enough to send patients insane so a predisposition to mental illness may exclude the patient from getting a transplant. A common response to liver transplants is a period of psychosis. The ability to quickly recover mental equilibrium is crucial to survival since life with a transplant is a deadly walk between organ rejection and immune-suppression illness.

Social Stability, Friends and Money are Crucial

Television current affairs programs present smiling transplant recipients who are going "back to work" as if they have recovered. Waiting list doctors hold a different view. They know the recipient will never be cured and will need a dedicated network of helpers therefore social stability is crucial. A transplant

hopeful shouldn't be chased by the police, neighbours, criminals, drug dealers, lawyers, television camera crews, welfare officers or have constant financial or legal threats to their well-being. A "good" home with friends and relatives is crucial as vital organ recipients are usually on the verge of serious illness. Money is important as surroundings should be conducive to keeping the life-long patient safe and secure. All this excludes large sections of the underclass.

Courage and obedience are needed to face the horrors of surgery, biopsies and drugs. Drug compliance is necessary because a recipient needs to maintain intake of anti-rejection drugs while observing them create new diseases like cancer tumours, diabetes and organ failures. The patient must not stop using the drugs that are causing harm because the immune system will then begin rejecting the transplanted organ long before the patient senses it. Mental and physical stamina are required to undergo painful and dangerous check-ups that are a regular feature for vital organ recipients. This form of obedient courage removes another range of personalities from receiving an organ.

Lacking the above qualities or positive circumstances will hinder the patient's chances of simply getting on the waiting list. The time on the list may be a few months or a few years. The patient might die on it or be taken off because other illnesses develop that lessen the ability to survive surgery. A positive reason for leaving the waiting list is when the patient recovers enough health and proceeds to less drastic and more successful treatments.

Tissue Matching

Upon the patient reaching the waiting list doctors begin compatibility ratings that indicate how well the body will accept foreign organs. Human Leukocyte Antigen (HLA) or tissue match testing involves mixing blood serum from the recipient hopeful with equal amounts of cells from sixty different people. The serum is classed as a 100% match if it doesn't react with any of the sixty samples. This means the recipient, with luck, will minimally reject organs from most other humans. A patient with less than a 20% match, indicating a strong, antagonistic reaction to alien cells and organs, may be removed from the waiting list.

The immunological hypersensitivity test also measures reactivity acquired from previous transplanted material and pregnancies. When a patient is seeking a second organ the first transplant organ must be considered because the recipient's immune system is fired up and full of hate for organs or body material from donors with similar HLA matches and blood groups as the first transplant. Therefore, the second transplant must come from a donor with a different Human Leukocyte Antigen (HLA) type otherwise the immune system reaction may be too savage.

Even a simple blood transfusion may have sensitised a potential recipient against people with similar tissue types as the blood donor. Therefore the recipient should not receive an organ from a donor with a

similar blood or HLA type as any of the people from whom blood has been received. It is a very complex situation.

The Mother's Immune System Tries To Kill the Growing Child

A woman's immune system initially experiences the growing embryo as a malignant tumor. It attacks the unborn child with intent to kill, but the embryo (or foetus) disables this attack and the mother's body begins accepting the child as part of herself, but not before it has permanently recorded the baby's HLA and blood type as an enemy to be attacked in the future. Therefore transplant technicians need to identify the blood and HLA types of all previous pregnancies of female organ recipients.

The above shows how crucial it is to identify all previous transplanted material, pregnancies and blood transfusions. Transplanting an organ or body material type that the recipient's immune system has already experienced could trigger an instant and deadly antibody attack on the new organ of a ferocity usually reserved for xeno or animal tissue transplants.

The next matching process is blood compatibility. Transplants often require huge amounts of transfused blood. Those lucky enough to have AB blood can accept all blood groups. A person with A blood can only receive from A and O blood groups. A person with B blood from B and O and someone with O blood can only get blood from a donor with that blood type. So if you're AB this increases your compatibility for both blood and transplanted material. This means a patient with AB blood will find it easier to get on the waiting list and a transplant.

Your Waiting Ticket

Doctors will examine your Human Leukocyte Antigen (HLA) and immunological hypersensitivity test results and assign a Percent Reactive Antibody number. A lower reaction to other humans' body materials indicates an ability to accept a wider range of donated material. This means that when someone is declared brain dead you may jump the queue over those who have higher reactions.

Other Factors Helping the Patient Move up the Waiting List

Being Young Is an Advantage

The younger patients move quicker up the list. They get priority because they are more likely to survive surgery and the drugs and will live longer if they do. Surgeons see less point in sewing scarce organs into some old dear who is approaching death. This is the cruel truth.

Being Close To the Harvest Hospital Is an Advantage

When three patients have equal seniority the one closest to the harvest hospital will win. Distance between donor and receiver is crucial. Hearts last about six hours between bodies so even a three-hour flight between cities plus courier times may be too long. Heart transplant failure rates increase 6% for every hour a cold and paralysed heart sits in that cold picnic container. The recipient-hopeful in the same city as the dying donor has an almost insurmountable lead over a similarly matched person in another state.

Avoiding Debtor Hospitals

A patient waiting for an organ in a creditor hospital gets priority to a patient in a debtor hospital. A debtor hospital has taken more organs from elsewhere than it has given and must start paying back. If your hospital or state has been sending its donor organs interstate then eventually this factor comes into play. This means that if you and an interstate person have equal priority and compatibility then you will win because the debtor must begin paying the debt. Of course, it also works the other way around.

Time on the list is also a determinant. The longer you've been there the better your chances unless you've lost strength while waiting. In that case doctors will kick you off the list.

Suddenly Deteriorating Health May Be An Advantage

Another factor is deteriorating health. The patient may be next in line for the heart of someone who just had a car smash, but if another patient further down the list suddenly begins dying then that person may jump in and get your heart. On the positive a patient ahead may become too ill to undergo surgery, or simply die, or get a cold that precludes surgery for two weeks. Then you jump in laughing, though not too loudly, and get that heart.

The Waiting List May Be Harder Than the Transplant

Getting to the top of the waiting list may take years of stress and chance. It may wreck what is left of your life and you might not even make it to surgery. Dr J.A. Roberts, of the Royal Hampshire County Hospital in United Kingdom, said that patients' lives can be destroyed by the emotional turmoil of waiting for a transplant, not knowing whether it will ever happen.

This isn't a joke because even someone dying over a period of years can have positive inner and outer experiences. Undergoing the horror of getting onto the waiting list and then the stressful wait can destroy that stability. Then the transplant may fail and the patient dies. One might then ask if the process was worth it.

The Big Day

The Big Day arrives. The hospital phones and says you are third in line. Your donor has terminal brain injury and is about to be declared brain dead. There are two recipients ahead of you. The ambulance has taken the first to the hospital for theatre preparation.

This is mind-breaking tension and you may find yourself hoping the two people ahead of you will suddenly die or that they have colds or minor infections that temporarily preclude them from a transplant. During the pre-transplant immune suppressant treatment or after the graft, a tiny cold or minor infection can become a deadly illness and kill the patient.

A further problem may arise if a famous television celebrity or a favoured doctor or Bill Gates wants that same organ.

Then the good word arrives. For unspecified reasons the other two have dropped out. You are number one and in the ambulance heading for transplant surgery. There is now a fourth patient behind you hoping you will fail and he or she gets the heart that is still beating in the prospective donor.

Last Disease and Deformity Check

While the donor is declared brain dead and moved to the harvest table last minute medical and social history checks continue. Personal history checks are required to ensure donors haven't recently worked as prostitutes and that men have not had active homosexual activity since 1976. Donors must not have HIV-AIDS, evidence of prion diseases or other infectious agents. An exception to this strict regime of disease control is the new policy in the United States approving some donors with localised cancer for organ harvesting. They are desperate to beat the shortage of donors though, even in the USA, cancer generally precludes organ donating.

Ex-Organ or Human Growth Hormone Recipients Can't Be Donors

Previous transplant recipients cannot donate organs because the attendant immune suppression they experienced has filled their bodies with powerful and diabolical diseases. Those receiving Human Growth Hormone injections from pituitary glands taken from human corpses preclude them from donating due to fear of latent Creutzfeldt-Jakob disease. Donors can't have lived in Great Britain for more than six months between 1988 and 1996 (unless they live permanently in that country), this again from the fear of vCJD, a human form of Mad Cow Disease. Prion diseases have incubation periods of up to fifty years.

Size Does Count

The donor's organs must be a similar size to the recipients. Transplants have been cancelled due to the shocking discovery that the donor's heart was too big. During harvesting the organs are checked for abnormalities. Smallish tumours are cut off the liver but if too large or extensive it is rejected and the transplant cancelled. New surprise illnesses or infections may be discovered during harvest. The car smash or injury, which broke blood vessels in the donor's brain, may also have damaged the transplantable organs. Fatal auto smashes are violently traumatic and frequently ruin the vital organs. Or the bullet that killed a gunshot victim may have pierced the organ. The medical literature also contains references to surgeons ruining organs during the complicated process of excision. All the above obstacles must be surmounted to obtain a scarce vital organ that may cost $300,000 to transplant.

Preparing For Theatre

Heart, liver and lung failure patients reaching theatre for a transplant are in the minority. The majority fail to make the waiting list and up to 9% on the waiting list for hearts are removed because their health has improved.

Then comes the preparation at the hospital. The skin on the area to be cut open will be shaved and disinfected. A paralysing drug and anaesthetic are administered similar to those given the donor and, hopefully, the roles won't be confused. The harvested body, after vital organ removal, may be sent to the skin and bone harvesters or directly to the morgue awaiting collection then taken to a funeral home. The transplant surgeons will not remove the failing organ from the recipient until they see and confirm the health of the harvest organ. They take this precaution because the plane or car carrying the organ may crash or it may arrive spoiled or defective. An exception is when the patient is about to die anyway and harvesting is happening in the same hospital.

Kidney transplants are easier. Unless the recipient's natural kidneys have cancer, or are previous transplants being rejected, they may be left in the body and the transplanted organ plonked into the patient's abdomen then connected from there to the renal system. Inserting a third kidney in the abdomen is such a smooth operation that recipients are often discharged from hospital before the living kidney donors (the walking around types) get out. Removing the donor's kidney involves cutting muscle tissue and even sawing off a rib, far different than a relatively gentle insertion of the harvested kidney into the abdomen of the recipient.

Living liver section donors have it worse than living kidney donors and can expect to lose eight kilograms and return for repeat surgical repairs. A healthy person donating a liver section undergoes risky surgery with full anaesthetic that may damage the brain. Some living donors even die.

When the donated organ has been cut from the dead or almost dead patient it is paralysed or stabilised, chilled and washed of blood and delivered in an ice-packed picnic cooler to the recipient's operating room which may be across the hall or across the country.

Bloodless Liver Surgery?

Liver transplants are the most difficult and expensive and very bloody. Four major arteries are cut and blood flow re-routed through the body. One transplant can use ninety litres of blood. During the 1980's a city's blood supply could be used on one liver transplant.[53] Nurses have reported being metaphorically "up to their knees in blood."

To reduce blood use during the transplant it is caught in a trough, cleansed and pumped back inside the body. Ironically, some liver transplants are done without using blood transfusions. In May 1999, Belgium surgeons transplanted a liver, without transfusing blood, into a Jehovah's Witness.[53]

Denton Cooley ranks along with Christiaan Barnard and Norman Shumway as one of the world's greatest transplant surgeons. He has done numerous transplants without blood transfusion and is, predicably, a hero of the Jehovah Witness religion.

Just surviving liver surgery itself, which can take twelve hours, is an accomplishment. The added hurdle is that unlike heart and kidney transplanting there isn't an effective liver replacement machine so if the transplanted liver doesn't quickly begin working the patient usually goes into a coma and suffers brain damage then death. Even surviving can be bad. Mark Dowie has described it in his book *We Have A Donor,*

> "The post operative course can be so much worse than the end-stage disease itself that the families have been known to

> pray for a merciful death for their loved ones – lying semiconscious, half-crazed by chemical imbalances in the brain, racked with pain and fever, and deeply depressed. Nurses and health workers often wish that liver transplantation had never been started in their hospitals."[54]

Jennifer Rickman in The United Kingdom

British transplant survival rates are higher than American rates because they too avoid transplanting into the sickest patients who, ironically, could extend their lives with a transplant.

Jennifer Rickman of Winchester, Hampshire, in the United Kingdom, had bronchiectasis since childhood and in 1997 at age 54 was put on the waiting list for a double lung transplant. She felt uneasy knowing she was waiting for someone to die. One day the hospital called and she was taken by ambulance for surgery, but the donor lungs proved unsuitable for transplant.

Jennifer then received another blow. After two years of psychological agony while waiting for the transplant a doctor told her she was too sick and that transplanting lungs into her was "little better than throwing the organs in the dustbin". Jennifer was devastated and didn't understand how she could be kept seriously waiting for lungs then suddenly reclassified as too sick. Next day she heard a news report that hospitals were now required to publish death lists and that surgeons would be reducing risky surgery to keep their death figures down.

Inga Clendinnen in Australia

The redoubtable Inga Clendinnen describes her liver transplant thus,

"Laying still for twelve hours or more can lead to the blood pooling, which is dangerous. So from time to time they pick us up by the feet and shoulders and shake us."

Another unusual procedure for a human with liver failure, who may or may not be awaiting a transplant, is to have pig or baboon livers connected to their blood stream. The animal livers then cleanse the blood similarly to a human liver. Baboon livers last up to 24 hours while pigs' last less than nine hours. Baboon livers cleanse best but pigs are preferred because baboons cost too much and look like us while people tend to dislike pigs.

The liver transplant recipient may go temporarily insane after a liver transplant due to the build-up of toxins in the blood stream that cloud the mind. Transplanted livers are notoriously slow to regain full function.

Heart Transplant

Dead bodies rot quickly in a hot jungle, yet if you die on a glacier your body could still be there in ten thousand years. Surgeons use this principle when performing heart transplants. The recipient's body is chilled to 77 degrees Fahrenheit slowing the metabolism and the need for oxygen. This reduces the risk of brain damage and brain rot. An anaesthetised and chilled body has a slower metabolism because it is slowed down to the edge of death. The anaesthetist is the "stage-master" poisoning the patient to the edge of death but still alive. This helps prevent the body from rotting and reacting to the knife.

Surgical procedures have improved since Washkansky's 1967 transplant but surgeons still, somewhat savagely, cut the patient open. Christiaan Barnard described it thus,

"...massive trauma of open heart surgery. His chest had been split open by knife, cleaver and saw - cutting through tissue, muscle, nerve and bone. Its ragged gap had been pulled still further apart by steel retractors."

The donor heart is paralysed then removed from the previously heart-beating donor for its journey to the recipient. A removed heart has a natural pacemaker and if kept in a nutrient solution could arrive for the recipient still beating, but this would cause damage like running a pump dry.

When transplanted the harvested heart starts beating on its own or may require a jolt of Direct Current electricity just like Frankenstein's monster. The present day process is more reliable than during Washkansky's time because the harvesting of hearts begins while they are still beating inside the donor. Previously hearts wouldn't always begin beating or would not beat properly because they had been damaged during the lengthy dying process.

Patients with Two Hearts

In the early days surgeons averted the risk of patient death, due to the transplant heart not performing, by leaving the old one in. These heterotopic transplants meant the old heart remained and a second heart was squashed in beside it. Patients then had two beating hearts which was quite good insurance. Mr Goss of South Africa was one such patient. Christiaan Barnard recounts in his book, *Second Life,* that when Mr Goss felt his natural heart stop he calmly got into his car and drove to the hospital with his transplanted heart still beating. Barnard also said that, as of 1993, one man had lived 17 years with two hearts.

What If The New Organ Doesn't Work?

The reader might be wondering why a patient on the operating table, whose transplanted lung, heart or liver has failed to function, couldn't continue living until another organ was located.

Theoretically, this is possible but the cost of keeping patients for months or years on heart and lung machines, or filtering their blood through three pig livers a day, wouldn't be sustained by government medical services or insurance companies. Also, animal rights activists wouldn't tolerate herds of pigs being slaughtered for that purpose.

Maintaining these patients isn't worth the trouble so when a transplant of this sort has obviously failed theatre staff will turn off the patient's air and quietly wait a few minutes for death. This is cheaper, more humane, less degrading and less painful for the patient, and a form of euthanasia.

Post-Operative Conditions

Pre-loved organs are like reconditioned car engines. They rarely work as well as the original motors. The problem with lung transplanting is that surgeons don't have the technological skills to connect the tiny nerve endings between the new lungs and recipient's body. This means lung recipients don't have our natural reflex reactions to irritants. When a normal person breathes in pepper, liquid or dust the reflex action prompts a cough to expel the material. Transplanted lungs don't have this healthy reaction and consequently these irritants build up so the patient must consciously and artificially cough and also make frequent visits to the hospital for lung drainage and cleansing.

The Transplanted Heart

Heart surgeons face a similar problem and can only connect the major blood vessels and nerve endings between the donor heart and recipient. The loss of these subtle nerve attachments means the transplanted heart won't initially beat at appropriate speeds and the patient may require a pacemaker.

A normal heart increases speed to meet higher energy demands but when a patient stands up the transplanted heart fails to increase speed resulting in fainting spells. This is why new recipients appear so fragile and walk in slow motion. The situation improves as the human body rewires its nerve routes between the brain and transplanted lungs and heart though this explanation is still unproven.

A second theory is that new connections are hormonally mediated rather than rewired, a stronger view, perhaps, since heart recipients don't feel

the usual pain associated with angina because certain nerve connections are never re-routed.

Like reconditioned engines another problem with pre-loved hearts is their rapid deterioration. Coronary arteriosclerosis appears in 90% of transplanted hearts within five years and the patient can't get bi-pass surgery but will need another transplant (if one is available). This is called a re-transplant and the survival rates are lower than for the first transplant. [55]

Long Term Recovery

For neurotics or hypochondriacs a transplant is a dream come true and bringing many new, exciting and deadly illnesses. The patient will be on a constant series of antibiotics and other drugs to fight germs the suppressed immune system can no longer battle. The transplantee's immune system may be too compromised to even share coffee cups and will need to avoid those with colds, avoid public toilets, and not eat raw eggs, uncooked dough or lightly cooked meat. Working in the garden may be too dangerous as a scratch could easily turn into the patient's last infection on this earth. The best part will be that doctors and friends won't deride or laugh at the new ailments since the hypochondria will be a reality.

Patients can expect new illnesses like high blood pressure, organ failure, diabetes and even cancer that will pop up from nowhere. Rejection will be the biggest problem and the whole family can spend hours playing 'spot the rejection symptom' before it becomes overt and it is too late to save the organ. The recipient should also like pain, as there will be considerable physical and mental anguish.

The Alligator Clip

Heart recipients need to regularly visit special doctors for rejection checks. This is tested by cutting a hole in the neck artery and pushing a cord, with a tiny alligator clip attached, down the artery into the heart where it chomps out a piece of flesh. The doctor pulls the cord back up and sends the chunk to the lab for analysis. Doctors will change or increase drugs at the first sign of rejection though it may be too late.

Patients ideally require monthly alligator clip tests to maintain the fine balance between rejection and immune deficiency diseases, but due to their unpleasant and dangerous nature these tests are done each six or twelve months. One problem is that the alligator clip might prompt a cardiac arrest creating a situation where it may be too dangerous to yank it out.

After a vital organ transplant life is never again assured and as Inga Clendinnen puts it in her book, "Tiger's Eye",

"We know that for us health is an artificial condition. We will remain guinea pigs, experimental animals for as long as we live or, if you prefer, angels borne on the wings of our drugs, dancing on the pin of mortality. We know that today is as contingent as tomorrow."

US$ transplant prices in 1996. First Year Charges (UNOS)		
Organ To Be Transplanted	Cost To Transplant	Annual Maintenance
Heart	253,200	21,200
Liver	314,500	21,900
Kidney	116,100	15,900
Pancreas	125,800	6,900
Heart-Lung	271,400	25,100
Lung	265,900	25,100
Kidney-Pancreas	141,300	16,900

Chapter 16

Religion and Harvesting

A keen feature of transplant agency promotion material is the "dispelling the myths" section where they supposedly throw the light of truth on erroneous myths allegedly held by the ignorant, common people. One “myth buster” statement is that all major world religions support organ donation. Some web sites even list dozens of religions saying all except Gypsies and Shinto support organ transplantation.

Most religions do support the attitude of helping others via personal sacrifice and that may include organ donation. But this view is often based on an ignorance of harvest processes. The hierarchical structures of many large religions I’ve contacted have yet to formulate their policy or provide clear guidance on this issue. Most put strict guidelines that donors should be dead and donation made voluntarily, both issues of which the organ harvest agencies gloss over and misrepresent.

When comparing the theology and recommended personal practices of major religions one observes they rarely complement what happens during harvest and transplant processes. A healthy, walking human letting harvesters remove a healthy kidney and insert it into the abdomen of a sick person appears the action of a saint and commendable by any religion.

But other facts should be added to the discussion. The previously healthy donated kidney will become sickly and probably fail within six or seven years and the patient want another. Many recipients won’t experience a sparkling new health but will suffer a series of new illnesses from the anti-rejection drugs. Their desperation to improve the health level of their carnal lives, at any cost, appears not the sign of someone who believes in life after death, but rather someone who believes in nothing and is desperate to hang on to any sickly state, at any cost, rather than die.

Below are views of some religious groups whose opinions may differ from those attributed to them by organ harvest agencies.

Church of England in Australia

Dr Robert Claxton representing the Sydney Diocese Secretariat of the Anglican Church wrote me saying The Church supports organ transplantation with the Holy Scriptures being the final authority and that "All organ/tissue donation therefore must be carried out with due dignity and with full informed consent by the donor (expressed before death) and the family."[56]

This requirement of full informed consent contrasts with South Australian and other legislation around the world. Harvesting approval doesn’t always require donor consent and a bureaucrat can order it with just family consent. If they aren’t contactable within an undefined "reasonable period" a government bureaucrat can decide, without consent from donor or relatives, if there isn’t a

reason to believe the deceased would have been against it. This would appear to conflict with Church of England policy as stated by Dr Claxton.

The reader can test public understanding of transplant procedures by discussing the issues of this book with prospective donors to discover if they are fully informed about the process.

Catholic Church

His Holiness Pope John Paul II said, in his address to the International Conference of the Transplantation Society, on 29 August 2000, that organ transplants which save lives are a good act but that the declaration of brain death must involve *"the complete and irreversible cessation of all brain activity (in the cerebrum, cerebellum and brain stem)"* [57]

Australian harvesting practice contravenes the Pope's guidelines because it doesn't require EEG testing to ensure the donor's cerebral electrical activity has stopped. Australian practice approves harvesting regardless of brain electrical activity. Queensland Right to Life says,

> *"The Catholic Church and most other denominations do support organ donation from the bodies of those who have had complete and irreversible cessation of all brain function, which is the legal standard for brain death in Australia. However, most Australian units do not meet the legal standard. The Australian practice is to use the clinical criteria alone which means that in about 50% of Australian diagnoses of brain death some brain activity still occurs. This is much more liberal than standards in Europe which generally require ancillary testing to establish that all brain function has ceased. Thus the Australian practice is not approved by the Catholic Church."*[58]

Pope John Paul II also said,

> *"...any procedure which tends to commercialise human organs or to consider them as items of exchange or trade must be considered morally unacceptable, because to use the body as an "object" is to violate the dignity of the human person"*[59]

Kidneys and corneas aren't sold in Australia or in most "developed" countries but governments are open about the benefits of these transplants. It is cheaper to transplant a kidney and supply drugs than provide long-term dialysis. It is cheaper to transplant a cornea than provide home care for a blind or semi-blind old person. It could be reasonably assumed that these transplants are not only acts of mercy but also performed for financial reasons.

The Jehovah's Witnesses

The Jehovah's Witnesses haven't provided a clear statement to me on their policy. The harvest agencies say the organisation allows individual Witnesses to make their own decision. Both harvesting and transplanting may involve

transfusions of blood especially during the removal or fitting of livers. Transfusion is a taboo act in the Witness faith. There are occasions of bloodless transplant surgery using the recipient's pre-stored blood and artificial blood, but the general reality is that transfusions would be required during both harvesting and transplanting, making this form of surgery taboo for Jehovah's Witnesses.

With harvesting the theological argument would be at what point death occurred in the donor and whether blood being transfused during harvesting is going into the person with a resident soul or just a corpse.

The Eastern Church (Greek Orthodox)

Even the donation agencies are wary of stating that the Greek Orthodox Church supports organ harvesting. Statistics show countries with large Greek Orthodox congregations have low harvest rates. Their resurrection doctrine, similar to Orthodox Judaism, states the body is resurrected as it is now. The interpretation may differ between a physical or a spiritual body, but the idea of being buried with parts of the body taken out or, other people's parts inserted, is seen by some as spiritually unpleasant at best.

Dimitri Kepreotes, Secretary to Archbishop Stylianos of the Greek Orthodox Church in Australia, says that His Eminence is considering the matter and will consult expert medical opinion.

Buddhism

The Buddhist understanding is that life is a continuum. We are not separate entities and any feeling that we are is a delusion that can be removed through quiet meditation. Actions to increase personal wealth or dominance are ego-based and represent a crude understanding of reality. Allowing the body to be born and to die on its own is a natural process and should not be seen as a defeat or disaster, but merely a change of consciousness. Therefore, the somewhat harsh act of removing a donor's vital organs, and using vast resources to fit these organs into another body, are an act of crude ego delusion and may represent a limited understanding of one's spiritual identity.

Tibetan Buddhism

In the Tibetan *Six Yogas of Naropa and Teachings on Mahamudra* it is said the dying person experiences the different elements dissolve and the element of prana dissolve into the consciousness at the Heart Centre. Then the white Tig Le in the Head Centre will descend and the Red Tig Le in the Navel Centre rises and the two will join in the Heart. Every human will then see the Light of Death but most will fall back into the Bardo, or astral form, and prepare to be reincarnated.[60]

The above is a simplification of a complex series of psychological and spiritual changes that occur during the process of physical death. According to Buddhist teachings, even after the conscious mind and brain processes have slipped into inertia and apparent death, the spiritual process continues. Buddhist scriptures

say clarity of mind is crucial during the dying process as it determines the quality of one's next incarnation. Practitioners of this path practice throughout their lives to clear their mind of delusion and retain this clarity while dying.

Therefore, it would be crucial for spiritual progress for the practitioner to experience a calm dying process free from injections including psychiatric drugs such as chlorpromazine that may be used in the harvesting process. Raising the blood pressure and the process of removing organs while the heart is still beating and pumping blood might dramatically and detrimentally cloud the process of the transformation that we call dying. This would be especially disturbing if an element of consciousness remained at the body during the preparation and harvest process.

Thailand

In Thailand, where being a Buddhist novice monk is a form of national service, a brain dead person is legally still alive.

China

In China, a nominally Buddhist culture, there is virtually no voluntary organ donation. The Chinese consider organ "donating" a form of punishment reserved for those found guilty in a court for murder, corruption or wrong political views. The government performs tissue matches and disease checks of prisoners. When a rich Chinese or foreign customer arrives with enough money or power the hospital agent shoots the prisoner to produce a condition close to brain death. The "donor" is shot in the head when the heart or torso organs are required and in the heart area when eyes are being purchased. Kidneys were removed from one prisoner after, rather than before, harvesting.

The idea of being a voluntary donor in China is a bit like being a voluntary prisoner. Quite unpopular.[61]

Shinto (Japanese)

Shinto has a direct religious doctrine against organ harvesting and transplanting.[62] It is considered spiritually dirty and foul. In 2000 there were six brain dead donors in Japan compared to 196 in Australia, which has one-seventh the population.[63]

Despite having huge numbers of dialysis patients, harvesting from brain dead and cardiac dead donors is almost non-existent in Japan. Japan has advanced medical technology and allows the unusual practice of removing kidneys, upon family consent, from cardiac dead donors who hadn't signed donor cards. In other countries these kidneys are considered unusable. Despite this relatively benign form of removing this organ Japan had only eighty cardiac dead kidney donors in the year 2000.

Gypsy

Gypsies include a range of peoples originally from India who have lived for centuries in the Balkans. They are a puritanical, travelling people who range though Europe, North America and Australia. "Gypsies have direct religious doctrine against organ donation" [64]

Church of Scientology

Janine Werneburg, speaking for the Church, says that founder, L. Ron Hubbard, states in the books, "Dianetics" and "Clear Body, Clear Mind", that the unconscious mind observes and records everything. Therefore, Janine says, the human subconscious may be experiencing the evisceration process despite severe brain injury or "brain death". Upon real death the spirit would carry that terror and when reincarnated this would cloud that incarnation until cleansed. The Church allows members to make their own choice.[65]

Hinduism

The great Swami Yogananda, of the Self-Realisation Fellowship, certainly experienced the problems other people have in ascertaining brain and physical death. He went to the United States of America to spread his spiritual teachings and practices. At the height of his success in the early 1950's he went into a sublime Samadhi where his body entered the traditional suspended animation. All functions stopped yet his body stayed fresh because samadhi transcends the process of life and death. His American followers, not understanding samadhi and, behaving a little like overzealous harvesters, thought he was dead and threw his body into a cremation fire. You can imagine the dismay his more knowledgeable followers experienced when they returned to discover what had happened. Fifty years later these older followers still can't talk about it.

Esoteric Hindu practices bring about a range of varied states of being that aren't understood or respected by non-practitioners. The idea that death can be determined by the simplistic testing of reflexes and bodily functions is seen as crude and childish. The thought that death is determined by non-practitioners, who work in the same rooms as those that seek one's organs, is anathema to most Hindus.

Islam

Islam says body parts shouldn't be stored which precludes eyes, perhaps kidneys, bones, skin, tendons, fascia, and body hormones from being harvesting. This will depend on their definitions of "storage".

Judaism

Brain stem death is not recognised by orthodox Jews as death of the individual because they believe the heart is the centre of the soul. The heart must stop permanently for death to have occurred. Burial must be as whole as possible and parts of the body removed due to disease or accidents must be properly saved and buried to Jewish Law when the person dies. Blood donations aren't allowed in

Orthodox Jewry. During the wars with the Arabs some Jewish soldiers wouldn't donate blood as this went against their beliefs.

Hmongs

The Hmongs of Laos and the highlands of Vietnam believe one of a person's three spirits stays with the body. Therefore, it needs to be whole and treated with appropriate respect and rites during the dying process.

Zombie Cult

The Zombie Cult strongholds are in Haiti and West Africa, but indigenous peoples throughout the world are conscious of spirits within and without the human body. The Zombie Cult has two arms, one scientific and one occult. Both involve Bogons, a type of witchdoctor who specialises in magic spells and spirits. The power of Bogons is believed and experienced by many peoples. In Australia the Pitjantjatjara people of the inland have Nungharis who cleanse the souls of patients in the "dream state". Aboriginals also have the feared Feather Men.

Scientific Bogons (Zombie)

The Haitian scientific Bogon is employed by someone who wants zombie slave workers or to rob an enemy of their "soul". The Bogon secretly administers naturally occurring poisons into the intended victim that create the appearance of death. The Haitian funeral is frequently hurried and the victim buried in a coffin. Later, the Bogon digs up and revives the victim to a semi-conscious state. The victim suffers injury from the poison and doesn't remember who he or she is. The apparent death state required little oxygen, but the victim might still have suffered brain damage in the oxygen deficient confines of a buried coffin.

The semi-zombie slave is delivered to the purchaser who adds controlled amounts of poison into the prisoner's food to maintain the zombie state. Zombies may spend the rest of their lives in this semi-conscious state. Occasionally a zombie has regained partial consciousness and escaped though even then may never regain a sense of self.

Occult Bogons

Many Africans around the world believe the occult Bogon uses subtle secret spells to steal the spirit. An enemy may hire a Bogon to attack the intended victim. In Africa the victim loses a sense of self and awareness, becomes weak and falls prey to the dangers we all face. These include disease, physical attack, family estrangement, mental illness, drugs, suicide, financial ruin, etc. Fear of Bogons is still strong in parts of Africa and Haiti especially in the former where bodies are frequently found with parts missing. Some say it is organ robbers while others say it is Voo Doo bogons stealing their victims' spirits that they believe reside in certain organs.

When Western doctors and transplant coordinators pressure African-Americans to consent to the harvesting of vital organs from the breathing, pulsing, warm and

soft bodies of their relatives, well, it echoes back to the sound of a threatening Bogon chant.

Chapter 17

The Politics of Suppressed Death Statistics

Australia

Until 1997 patient and organ graft survival statistics were printed in the Australian and New Zealand Organ Donor Registry Annual Report (ANZOD).[66] Then they were excluded. Just like that. Crucial, easily understood survival data was excluded. These were the basic one-year and five-year survival rates, which are key indicators of the success of transplant technology. So why would such an important yet inexpensive data list be excluded?

I asked this question to the astute and usually articulate co-editor, Karen Herbertt, and this began a series of bureaucrat responses that exemplified the illogic that pervades the transplant industry.

Karen said they were short staffed and couldn't compile the data, an apparently reasonable response considering stagnant hospital budgets. Her answer, however, appears contradicted by the inclusion in her ANZOD 2000 Annual Report of complex survival data costing many times more to collect than the excluded basic survival rates.[66]

This complex and esoteric data includes donor details such as age, gender, occupation, ethnic origin, religion, virology screening, cardiopulmonary resuscitation, smoking and drinking status, refusal or consent of donor families, weight, health of donors, donor age of unsuitable kidneys, terminal serum creatinine and urea levels in donated kidneys, oliguria and hypotension effect on kidney graft survival plus pages of similar data for other organs. Also included are the time periods from admission to hospital to ventilation to brain death diagnosis and to the aortic cross-clamp application on the harvest table that terminates the patient’s life.

The ANZOD editors included tables listing usage rates of specific drugs to maintain harvest organs, data showing from which hospitals the donors originated and details of their deaths. Reasons for donor deaths include epilepsy, overdoses, hanging, melanoma, timber fell on head, run over by car, cerebral haemorrhage, hit by towbar, skateboard hit by car, football injury, hangliding, meningitis, shot by nail gun, choking, smoke inhalation and strychnine poisoning.

All the above make ANZOD Annual Reports fascinating reading, but fail to provide an overview of transplant effectiveness. It contradicts Karen’s statement that costs restrict compilation and publication of basic survival statistics.

Why Hide High Survival Rates?

The question kept arising in my mind. Why did they decide in 1997 to stop publishing survival rates in the ANZOD Annual Reports? A cynic could say that the more factual material people have about transplanting the more incisive the questions they can ask including the claimed 90% twelve month survival rate. One could also ask how the survival statistics are compiled. Are only reported deaths of transplant recipients used to determine who died? How do patients who tire of the anti-rejection drugs, and subsequently die, get recorded? Are normal death rates included? What is their standard statistic error estimate? And the big question – Why were the Australian survival rates so much higher than French, British and American rates and why was such a success suppressed? One would expect these issues could easily be clarified. Karen Herbertt suggested I contact the transplant hospitals myself.

I Smelt A Rat

So I phoned eight transplant hospitals around Australia and discovered that even receptionists could reel off the survival rates for organs their hospital transplanted. The only problem was when managers or senior doctors discovered my questioning and then stopped any further communication. They wanted to know my credentials and what exactly would I be writing and even then refused to supply percentages. It wasn't enough to be a member of the public wanting to know simple transplant survival statistics at a public hospital.

I phoned Karen again saying how easy statistics were to be collected if hospitals were willing to supply them. Much easier than compiling detailed statistics on the complex disease and other characteristics of donated organs that were listed in the ANZOD Annual Report.

She suggested I call Graham Russ of the ANZDATA Registry, another survival data collection agency, which publishes the ANZOD Annual Report. Graham Russ and Karen Herbertt, as well as having other jobs, are the co-editors of the ANZOD Report. Graham wasn't as fresh and clear as Karen and began made vague noises indicating he didn't understand what basic survival statistics were. He said ANZDATA, or whoever he was speaking for at that moment, were too busy and my request would go on the slow queue and cost a hundred dollars to print two pieces of paper. And he never even did that.

Matthew Hee, at the "Australians Donate" organisation, copied Graham's vague mumbling and, along with verbal responses, added high-pitched giggling sounds. Matthew said Bruce Lindsay was the person to speak to but, Bruce was never there and was either attending to personal needs, in a meeting or visiting a doctor. Other Australian donation agencies responded similarly – men mumbling and giggling and women becoming hostile and aggressive. The men must follow the same training manual.

Karen Herbertt was unusual. She generally responded to questions as if under an obligation to inform the public. The others acted as if briefed to deceive and confuse.

The Mythical 90% One-Year Survival Rate

During Australian school lectures transplant coordinators pretend to be unsure of exact survival data and will say 90% is the one-year survival outcome for vital organs. They call this their "ballpark figure". Ninety per cent survival may be true for kidney transplants, which aren't necessarily life saving procedures anyway, and for which the patients' survival rates may even be higher if they miss the transplant and stay on dialysis. The claimed 90% one-year survival rate for other vital organs appears to be deception.

The last published heart transplant survival statistics for Australia for 1997 were published by the defunct, *ACCORD*, a government transplant promotion agency replaced by the mysterious *Australians Donate*. *ACCORD* listed heart transplants as having an impressive one-year 90% survival rate. Incredibly the German survival rates listed in Mario Deng's study for 1997 were 71%. Even lower is the Henry Mondor Hospital in Paris with its large and experienced cardiac transplant unit having a 62% rate.[67]

The Clinical Effectiveness Unit of The Royal College of Surgeons of England, did a Cardiothoracic Transplant Audit for the years 1995 to 1999. The audit discovered that "Within six months of listing 52.5% of patients on the heart transplant list had been transplanted and 11.0% had died,…" while survival of those not getting a transplant was "After three years, the waiting list mortality was 16.9%…" The study concluded that

> *"Thoracic transplantation is still limited by donor scarcity and high mortality. Overoptimistic reports may reflect publication bias and are not supported by data from this national cohort."*[67a]

Even the Registry of the International Society for Heart and Lung Transplantation report a one-year survival of 78% in 1999. So what do the much higher Australian survival rates indicate?

Anne Keogh from St Vincent's Hospital in Sydney, Australians Donate and the International Society for Heart and Lung Transplantation told me in an email that we shouldn't be surprised by Australia's higher survival rates implying this is due to superior post-transplant aftercare treatment. Australia doesn't import human heart valves or cardiac tissue from United States and Europe because their disease-free and personal history standards are lower than in Australia suggesting the Europeans and Americans are killing patients by transplanting infected organs and materials into them.

This is a comforting thought but the Australian transplant industry now hides both its survival figures and collection methodology indicating something is amiss. Nor does the contemptuous reaction to enquiries instil confidence.

If Australia has such high standards of disease control and post transplant care then why is the industry unable to fund the collection and publication of simple

survival statistics? They spend millions on glossy pamphlet and television promotion. Even a fool would suspect a cover-up by both the government and industry.

Mario Deng's Study Conclusions

Mario Deng's team concluded that only patients with a high risk of dying on the waiting list improved their life expectancy with a transplant. This begs the question of why bother putting scarce transplantable hearts into people of medium and low risk of dying while on the waiting list when it doesn't improve their life expectancy.

The answer is that if all scarce transplant hearts were allocated to the most seriously ill heart patients then more life expectancies would be increased. This isn't done because they would still live shorter periods than those of medium and low risk who, perhaps unnecessarily, got heart transplants. This would reduce the average life expectancy of heart transplant recipients to such low levels that the public would question why we bother with the procedure.

To dissuade the public from asking this question scarce hearts are transplanted into less desperate patients and whose life expectancy, on average, won't improve. This less desperate group has such little use for a transplanted heart that 9% of them in Deng's German study were removed from the list because their health improved before a heart became available. [68]

This could again beg the question that the waiting lists might be padded with people who could benefit more from other forms of medical treatment. If the Australian 90% figure is true then perhaps heart patients in less need get transplants while those more desperate are left out to maintain higher transplant survival rates.

Chapter 18

A Short History of Human and Xeno Transplanting

Human Transplant History

From about 1700 human skin had been transplanted in India to burns, disease and injury victims.

1905 Frenchman Alexis Carrel began the modern age of organ transplanting when he developed a method of joining blood vessels.

1905 Human blood began to be transplanted with less than happy results because blood types weren't distinguished.

1933 Serge Veronoff, a Russian living in France, performed the first recorded kidney transplant without the benefit of tissue typing. It failed.[69]

1954 First Successful Kidney Transplant

1958 Dr Raben of the USA produced hGh (Human Growth Hormone) using harvested Pituitary glands from morgue corpses to promote growth in dwarfs and increase fertility in women who couldn't get pregnant. The Australian program began in 1965 and finished in 1985 both here and in most of the world due to the spread of Creutzfeldt-Jakob disease from infected glands.

1966 First simultaneous pancreas/kidney transplant in United States.

1967 First successful liver transplant by Tom Starzl in Denver, Colorado.

1967 Christiaan Barnard, in South Africa, transplants first human heart. Barnard was a son of a Christian missionary, screwed three separate women in one night, had two women at one time and also did it to Gina Lollabrigida. His second wife was 27 years younger than himself and his third wife 39 years younger and whom he met when she was six. Barnard's work suffered due to international sanctions against South Africa, his arthritis and refusal to leave his country. He was, perhaps, a great man.[70]

1968 First Heart transplant in USA

1972 Jean Borel discovers cyclosporin, the anti-rejection drug made from a poisonous Norwegian fungus. It was approved for use in 1983 and is still the most popular immune suppressant drug used in transplantation today.

1981 First successful heart-lung transplant in USA

1983 First single lung transplant (Canada)

1986 First successful double lung transplant (Canada)

1988 First combined liver and intestine transplant

1989 First successful liver transplant using a living donor. A portion of a living person's liver was cut off and transplanted to a relative.

1990 First successful transplant where a portion of a living person's lung was cut out and put into a relative.

2000 First successful lung transplants using organs harvested from cardiac dead (completely dead) donors. Performed in Sweden. Previously lungs were only removed from fully living or "brain dead" donors with beating hearts.

Xeno History

1628 Sheep blood transfused to humans in Padua, Italy.

1682 Bones from dog's skull transplanted into head of wounded soldier.

Late 1800's in England.

Sheep blood injected into wayward husbands and troublemakers to make them calm or at least sick.

Skin cut from living frogs and put on human burns and ulcers. Size of graft was determined by the wriggling of the frogs trying to escape.

1906 Princteau's failed attempts to transplant rabbit kidney sections into humans.

1910 Ernst Unger puts monkey kidneys into a human. They failed, as did his transplanting a kidney from a stillborn baby into a Baboon.[71]

1913 Serge Voronoff transplants thyroid of chimp into boy aged 14. Failed.

1914 Sheep's blood transfused to wounded soldiers.

1914 Bone transplant from animal to wounded soldier in France by Russian surgeon Serge Voronoff. [72]

1920-1923 Serge Voronoff does a series of testicle transplants from monkeys and chimpanzees to elderly men who reported renewed vigour.[73]

1923 Neuhof transplanted a sheep kidney into a human patient who died nine days later.

1958 First successful heart transplant, from one dog to another, by Norman Shumway in the United States. Norm was incredibly pissed off when Christiaan Barnard beat him to the human heart transplant, but regained his composure and became one of the leading surgeons in the world.

1963 Keith Reemtsma of U.S.A. transplanted a chimpanzee kidney into a human patient who lasted 63 days. Another one lived nine months with the kidney operating for six.

1964 Dr James Hardy of Mississippi did the first heart transplant from a chimpanzee into a human. The hospital allowed the consenting relatives to believe the new heart would be from a human. You can imagine their surprise when they discovered their child got a chimp's heart. The patient died during surgery. [74]

1965 Tom Starzl, sometimes known as FrankenStarzl, did six baboon-to-human kidney transplants. All kidneys survived hyperacute rejection but were destroyed within two months from human immune system attacks. One wild set of kidneys produced fifty litres of urine in 24 hours, which killed the patient.[75]

1966 to 1973 Tom Starzl transplanted three livers from chimpanzees to children. All died within fourteen days.

1968 Denton Cooley in Houston, Texas transplanted a sheep's heart into a human patient. Donald Ross in London, England transplanted a pig's heart into another human. Both hearts were attacked within minutes by the patient's immune systems and they died.

1977 Christiaan Barnard transplants two chimpanzee and baboon hearts to humans as auxiliaries until their own hearts could recover. The chimpanzee heart was rejected after four days. The baboon heart wasn't big enough to support circulation. Both patients died as their own hearts hadn't recovered.

1984 Dr Leonard L. Bailey, of Loma Linda Seventh-day Adventist Hospital in California, put a Baboon heart into a baby girl called Fae. The kid lasted twenty days. He said it gave him good practice. The hospital got 75 complaints about cruelty to Fae and 13,000 for the Baboon. Leonard Bailey was advised to wear a bulletproof vest. It was ironical that a church specialising in vegetarianism would be a leader in body parts transplanting particularly from animals to humans.

1992 Pig heart to human performed in Sosnowiec, Poland. It failed and the patient died.

1993 Leonard Makowka puts a pig liver into a human. It fails.

1992 and 1993 Tom Starzl did two baboon to human liver transplants. Both patients died. One lived seventy days. Protesters picketed his house calling him Tom FrankenStarzl. The name stuck.

1996 India Pig heart to human. Patient died and the surgeon jailed. When he got out he said he was going to do more.[76]

Experiments on Animals

After Tom Starlz' failed xeno transplants public and professional attitudes hardened saying that humans shouldn't be used for virtual experiments until further progress was made on reducing immune reaction to animal organs. The

focus then went on performing transplants between different species of animals and conditions, predicably, got rather nasty for the animals.

Duke University in the USA collaborated with Nextran Incorporated while Cambridge University of the UK joined with Novartis. They performed a series of experiments transplanting pig kidneys to baboons attempting to stop the hyperacute rejection of organs between species. The animals that received the transplanted organs survived from thirty minutes to 35 days.

Duke University/Nextran also did heterotopic heart transplants from pigs to baboons where the baboon hearts were left pumping but a functioning pig heart was also attached. Survival was from 6 hours to 5 days. The research scientists also did pig to baboon lung transplants with the baboons lasting as little as ten minutes to five hours. The sickening descriptions of these experiments are not worth printing but suffice to say that this is the high moral price we pay for developing transplant expertise.

Using animals for human transplanting has been with us since the 1700's, in England, when the bloodstream of a living sheep was attached to a patient with liver failure and in a coma. The sheep's liver cleansed the man's blood and he awoke full of vigour, but in what at best could be described as a strong display of ingratitude, he jumped out of bed and killed the sheep.

Christiaan Barnard used the same technique in South Africa when he wheeled a baboon into a hospital ward and attached its blood stream to a liver failure patient, who had fallen into a coma, and was at risk of brain damage from blood toxins. Barnard, perhaps hearing of the sheep story, covered the baboon so as not to distress others and sedated both the baboon and patient to avoid any unpleasant reactions. The animal's liver cleansed the human's blood and the man recovered. The baboon suffered little detriment except for temporary jaundice and a bad temper.

As stated elsewhere in this book, harvested pig and baboon livers are attached to human blood streams and used for temporary liver cleansing when a patient suffers short-term acute liver failure. The patient's own liver may recover or at least survive until a transplant liver is available.

Judith Brumm, a theatre nurse and clinical program coordinator at Baylor University Medical Centre in Texas, reports a pig liver used to keep alive a liver-failure patient. The pig was specially raised in a sterile environment. Its liver was surgically removed and placed in a dish next to the patient whose blood was perfused for seven hours over three days. It kept the patient alive until a transplant became available[76a]

Japanese Transplants

Transplantation's lack of popularity in Japan isn't purely because of the Shinto and Buddhist religions. Juro Wado did his bit as well.

Dr Wada, Japan's first heart transplant surgeon, found an eighteen year old drowning victim with a harvestable heart. His first mistake was declaring the boy dead instead of letting an independent doctor make the determination. His second

mistake was putting the boy's heart into a patient who apparently didn't need a transplant and, in any case, died twelve weeks later from organ rejection. An investigation indicated the patient only needed a valve replacement, a much safer procedure.

Dr Wada's reputation suffered further when the investigators discovered the deceased patient's original heart had disappeared and when found the valves had been removed and put in a separate place. When they were examined one had a different blood type suggesting the deceased patient's original valves had been removed to confuse the investigators. Dr Wada blamed the misplacement of the valves on a younger surgeon who had recently died of gastric cancer and, conveniently for Dr Wada, couldn't testify.

The Japanese prosecution charged Dr Wada with double murder saying the donor hadn't been proved dead and that the deceased recipient had only needed a simple mitral valve replacement. The charge was eventually dropped.

This was followed by a series of similar incidents leaving the Japanese public with major suspicions of transplant medicine.

Chapter 19

Trusting Your Hospital

If you use Frankenstein medicine you get Frankenstein results.

Professor Lynette Dumble[77]

In 1958 an American, Dr Raben, discovered he could obtain human growth hormone (hGH) from pituitary glands removed from corpses. The pituitary gland is pea shaped and located in a bone cavity at the base of the brain. Very short children grew to normal height and infertile women became pregnant by eating the corpses' growth hormone.

In Australia, when professionals are caught acting despicably, they blame their behaviour on influences from the United States. Yet during the history of the Human Growth Hormone program American doctors told patients hGH was obtained from corpses. Australian doctors deceptively said the Hormone was from a "natural source", but not that it came from dead bodies, which wouldn't have sounded too natural.

The Australian Human Pituitary Hormone Program began in 1965. The Commonwealth Serum Laboratory (CSL) managed the operation collecting the glands from morgues throughout Australia and processing them into hGH.

The pituitary glands were frequently removed illegally and without next of kin consent so CSL collectors avoided telling hospitals of their activities, instead approaching the pathologists doing non-coronial post-mortems. These post-mortems were theoretically done only for education and research purposes. Autopsy consent forms didn't always include the right to remove organs but some pathologist did so anyway.

The Australian practice of using hospital post-mortems as a deceptive means to remove body parts was also practised in Britain and many other countries. Relatives were approached for consent for a post-mortem in the interest of science but the real reason was to harvest organs and body parts. Even today some post-mortem consent forms have an organ donation clause slipped inside the text. Body parts may be removed regardless.

The Commonwealth Serum Laboratory still couldn't obtain adequate supplies of glands in Australia because pathologists in the program knew that removing glands for hormone transplant purposes could be a legal and public relations nightmare and were reluctant to become involved. In response, the Commonwealth Serum Laboratory (CSL) bi-passed the pathologists and bribed morgue attendants to remove the glands.

These morgue attendants, untrained in surgery, used a hammer and chisel to whack off the bone cavity holding the pituitary gland then put the jagged bone, gland and dangling veins into acetone fluid or directly into the freezer from where CSL collectors would sporadically pick them up.[78]

One CSL employee noted,

> *"We found, in the beginning, that supplies were sporadic, until we hit upon the simple expedient of bribing the post-mortem room attendants…"*[79]

Morgue attendants, including those at the Queen Elizabeth 2 Centre in Perth often used the bribery money for Christmas Parties. One attendant noted,

> *"…we'd use it mostly for our Christmas party. We used to have a pretty good morgue Christmas party."*[80]

Being paid made such a difference that one pathologist in Queensland noted,

> *"The attendants were pretty well drilled and they would remove the pituitaries and in fact if you wanted a pituitary for diagnostic purposes you had to stop them before they removed it. They automatically took them."* [81]

Another pathologist notes,

> *"We would grizzle every now and again because we thought we might have wanted the pituitary and it'd be gone you see,…"* [82]

Professor Margaret Allars, who headed the *"Inquiry into the use of Pituitary Derived Hormones in Australia and Creutzfeldt-Jakob Disease",* concluded that it appeared that gland removal was illegal when collection was used for hormone transplant purposes. A post-mortem, even with consent of relatives, was not a consent to removal organs. No one was ever charged.[83]

One morgue attendant described the attitude at the time thus,

> *"Permission to do the post-mortem would cover it because how many people know you're got a pituitary in your body."*[84]

Between 1965 and 1985 the program removed glands from 171,091 Australian corpses. It stopped in 1985 when American scientists warned the Australian Government that Creutzfeldt-Jakob disease (CJD) prions were being transmitted via hGH derived from infected pituitary glands. The fact that corpses were being robbed under the guise of post-mortems was not a factor in stopping the program.

Dr McGovern's Disease Warnings Ignored

From 1969 Dr McGovern, a leading Australian neuro-pathologist and member of the Human Pituitary Advisory Committee, advised the Commonwealth Serum Laboratory (CSL) that glands should not be taken from corpses where death was caused by "slow viral infections" that would have included Creutzfeldt-Jakob and Alzheimer's disease. In 1976 he was removed from the advisory committee

and in 1977 the Commonwealth Serum Laboratory "accidentally" removed his infection warnings on gland harvesting and collectors recommenced removing glands where prions were a possible cause of death.[85]

The Callous Treatment of Jane Allendar

The callousness of medical professionals could hardly be more distastefully displayed than with the 1988 death of Adelaide Hills woman, Jane Allendar. Jane became infected with Creutzfeldt-Jakob disease after receiving fertility treatment at the Queen Elizabeth Hospital in Adelaide from 1975. The Human Growth Hormone (hGH) used was derived from human corpses, in Jane's case, corpses of some who had died from Creutzfeldt-Jakob or similar prion diseases. These were just the type of corpses that Dr McGovern had tried to exclude from the harvest process.

It wasn't just the fact that Jane Allendar had died due to medical negligence but the nasty way she was treated during her lengthy dying process.

Doctors and medical bureaucrats associated with the Queen Elizabeth Hospital and the South Australian health system knew for some time how Jane had been infected and that she would die a slow, horrible death. But to protect their own interests they didn't bother to tell Jane or Ted Allendar despite the Allendar's persistent efforts to discover the cause. Eventually, near the end of her life, they sent a nurse to coldly inform Jane she had a terminal illness, cause unknown. But these medical bureaucrats knew all along.

Following her death Ted Allendar spent four years searching for the cause of his wife's death. By this time probably twenty doctors and medical bureaucrats knew what killed Jane but all feigned ignorance or just didn't think it was important to tell Ted. It was only in passing, at an Administrative Appeals Tribunal Hearing in Adelaide, that Ted learned that Creutzfeldt-Jakob Disease prions had killed Jane and had come from the fertility treatment derived from corpse glands - and that the doctors and bureaucrats had known for years even before her death.[86,87]

Chapter 20

Robbery, Crash Testing and Odd Things

"But obviously you do have to suspect something when the patient is a wealthy Rio socialite and her "donor" is a poor, barefoot "cousin" from the country." Organ Watch **Nancy Scheper-Hughes** [88]

You might have heard the "myth" about the man visiting a foreign country, going to a bar, invited for a drink by a young woman then waking up the next morning with a thankyou note and two sewn up wounds from where his kidneys had been removed. This often repeated tale might have taken place in a hotel room in any exotic city in the world. Its unreliability is used as proof that organ thefts and the organ trade don't exist. The practice of spreading an exaggerated tale is a method of intellectual trickery that harvest promoters use to reduce people's understanding of the organ theft industry.

Egypt

Egypt's prosecutor-general recently launched an investigation into a claim by Members of Parliament that 25 children from a homeless shelter were killed and their organs then sold, for between $9000 and the unlikely sum of $330,000, to wealthy patients in private hospitals. The Egyptian Minister of Social Affairs reportedly told parliament that an investigation found evidence of "financial and administrative irregularities and that the children's deaths were the result of gross negligence," but it wasn't exactly clear how the children died.

Guardian Weekly 28/3/99

United States of America

The American Red Cross was caught stealing the bones of Arizona woman, Heather Ramirez, who died in a car smash. Heather's parents had agreed to give her eyes to an Eye Bank and heart valves, veins and skin to the Red Cross, but not her bones. The Red Cross took them anyway. An employee forged Heather's father's initials on a bone consent form. After this discovery the Red Cross still refused to hand back the bones. Greg and Lucinda Ramirez sued the Red Cross

but it was not until two years after her death that the bones were returned. Red Cross spokesman Mike Fulwider said, "We are certainly deeply saddened by this," He didn't say whether it was the theft of the bones they were sad about or, getting caught.

The Orange County Register Newspaper, California. April 16-20, 2000

Lack of Respect

As well as 5500 brain dead and 20,000 cardiac dead donors there are also 17,500 bodies donated for medical and research testing in the United States. This includes those used by surgeons and students for practice sessions and as surgery models at conferences with audiences. Four thousand bodies are used for experiments including putting heads in helmets and then dropping them from a height to test the helmet's strength. Bodies are put in cars that are smashed against walls to test air bag strength. Arms are tied to snowboards then dropped to test wrist braces. Relatives are rarely asked permission. Russel Sherwin of the University of Southern California says he stopped asking permission because too many relatives objected.

From Ronald Campbell, William Heisel and Mark Katches. The Orange County Register Newspaper, April16-20, 2000

China

David Rothman of the Bellagio Task Force says that China's "insatiable killing machine" is driven by the rapacious need for fresh and healthy organs. Thousands of prisoners are killed each year as customers arrive for organ transplants.

Harry Wu, the Chinese political activist, speaking at a conference at Berkeley's Department of Anthropology, University of California said,

"I interviewed a doctor who routinely participated in removing kidneys from condemned prisoners…she had even participated in a surgery in which two kidneys were removed from a living anaesthetised prisoner late at night. The following morning the prisoner was executed by a bullet in the head"

Australia

At the Glebe Institute of Forensic Medicine in Sydney Professor Hilton repeatedly stabbed one body to gain knowledge for a crime trial. As mentioned elsewhere in this book, employees belted the head of a crime victim with a hammer for investigative purposes, removed spinal columns and performed nose jobs on bodies.

In the late 1980's pathologists in Queensland were caught taking heart valves during post-mortems that were legally limited to discover cause of death, but not for body parts harvesting.

Professor Margaret Allars said in her Independent Inquiry into the removal and use of pituitary glands from corpses, that non-coronial post-mortem consent forms were used to remove organs.

The Sydney Heart Valve Bank say their heart valves are collected from Cadaver Donors via "Forensic and Coroner cases".

The New South Wales Government Health Department sent me a range of post-mortem consent forms used in its hospitals. Instead of openly asking for organ donations New South Wales hospitals pretend to be asking relatives for a voluntary autopsy of the deceased, but the forms often have obscure clauses agreeing to body parts and organ harvesting. Relatives in shock could easily be fooled into signing away organs thinking the post-mortem was only to discover cause of death.

Craig Knowles, Health Minister of the New South Wales Government in Australia, has begun a campaign to stop the secret removal of parts and use of bodies without clear consent.

On 26 June 1989 harvesters asked Mike Wynne, of the southern highland region of New South Wales, to consent to organ removal from his "brain dead" nephew whose family had been killed in a car smash. Mike later said, "They didn't bully me into it, but they sort of did what seemed like a sales pitch." Mike, as the closest surviving relative, consented for certain organs to be removed because the boy reputedly had wanted to be an organ donor upon death. He didn't consent for his nephew's eye removal but the hospital took them anyway. Mike only discovered this when they sent him a bill for X-Rays. What most offended Mike was the reaction of the hospital. He said, "…I was treated with complete disregard afterwards." He also thought his nephew had been moved to another hospital in preparation for harvesting rather than treatment.[89]

Germany

The University of Heidelberg, acting on behalf of the car industry, used donated children's bodies for crash testing instead of dummies. Dummies cost two thousand marks while bodies could be obtained from the parents for a few hundred marks. [90]

Singapore and Taiwan

Japanese kidney patients travel to Singapore and Taiwan to arrange purchase of organs obtained without consent from executed Chinese prisoners.

England

Dutch Professor Dick van Velzen in Liverpool, England was caught after removing 850 organs from dead children for a research project without consent from parents. Rather than being a lone robber Professor van Velzen was acting out the status quo behaviour in the British medical system.

The Independent (London) December 5, 1999 and The Daily Telegraph (London) December 4, 1999

In 1992 Indian medical institutions were selling kidneys to private English Hospitals.

D. Brahams; "Kidneys for sale by live donors." Lancet

Israel/Palestine

As in China, where organ removal is a form of punishment for prisoners, so the removal of organs from defeated enemies may have become an Israeli spoil of war.

West Bank, 8th of February 1988

Nineteen years old Khader Elias Tarazi, a Christian Palestinian, went shopping for groceries in the Gaza. Upon returning with two bags on his bicycle he crossed a road near a stone throwing demonstration where the stone throwers were fleeing Israeli Army soldiers. Mistakenly they grabbed Khader and beat his head and body with truncheons. Nearby shopkeepers shouted Khader wasn't involved in the demonstration but soldiers, now nine of them, broke an arm and a leg. They continued the beating then threw him onto the bonnet of their jeep handcuffing the now unconscious Khader to the front crash bar. They drove off continually braking hard and he sustained further injuries including a broken back, skull injuries and his face kept banging against the bonnet.

The Israeli doctor at the Military Prison in Gaza refused to attend Khader because of his serious injuries and because there wasn't the necessary paperwork. He was taken to Ansar Two prison and thrown into a prisoner tent holding thirty to forty prisoners. They screamed that he must be taken to hospital and the guards responded by forcing them to strip naked and stand outside in the winter cold. Khader died in the tent and later was taken to Soroka Hospital in Beer Sheva and pronounced dead.

Khader's mother was outside the prison where Israeli officials denied they had a prisoner by his name inside. Later, they admitted he was inside but said he must have been very sick when he went out shopping because he was now dead.

Israeli officials refused to hand over the body and it was transferred to Abu Kabeer hospital, officially for a post-mortem. Mrs Tarazi told David Yallop that, during this time, many of the organs were illegally removed from his body.

No inquiry was made into the death and the Tarazi family were told if they continued to ask for an inquiry they would be looking for trouble. Five months later soldiers and secret police visited the Tarazi house at midnight, beat up Khader's brother and father and threw the former into Ansar Three prison.

2nd of April, 1988

Twenty-three year old Salim Khalef Al Shaer, of Bethlehem, joined a Saturday demonstration against the Israelis. One soldier shot him in the face from fifteen metres. To stop the Israeli soldiers taking the body for organ removal his friends

rushed the body to the closest mosque and called for the family. The funeral service began immediately. When the procession came out of the mosque for its trip to the gravesite the Army was waiting. Helicopters dropped teargas canisters and large stones onto the mourners. Ninety minutes after walking out of his house Salim was buried in his grave.

West Bank, 30th of October, 1988

When Roman Catholic Palestinians were leaving mass they were confronted by the Israeli Army and began throwing stones. Nineteen-year old Iyad Bishara Abu Saada was killed by a plastic bullet that cut an abdominal artery. The same grim chase for the body entailed. The mourners eluded the Israelis and Iyad was buried a few hours later. Somewhat predictably the Israelis fired teargas canisters into the family home four days later. Mrs Saada told David Yallop the practice of removing organs was common and named Arab and Israeli hospitals where she said organs were removed. She said doctors, accompanied by soldiers, offered large amounts of money to parents of the killed. [91]

Moldavia and India

Various suburbs and villages in India and Moldavia specialise in kidney selling where "donors" will be lured to hospitals or clinics away from their homes. They may be promised two thousand American dollars or complex surgery to remedy another ailment. After the kidney harvest the seller may not get full payment and usually won't be treated for any post-harvest complications.

Israel has a government policy of reducing dialysis costs by getting Moldavian kidneys via Turkish hospitals. The Israelis arrange Moldavians to travel to Turkey where doctors harvest one of their kidneys. An Israeli on dialysis, visiting Turkey, then gets the Moldavian kidney inserted into his or her abdomen and returns to Israel.

Some Indian cities specialise in supplying Arab organ buyers while other cities cater for rich Asian customers. Most participants get substantial rewards from the process except the peasants who provide their organs. Like the Moldavians some end up with little money and suffer health problems that the harvesters and organ recipients won't help with.

Chapter 21

Sociological Implications

Would you readily take your brain dead family member with a warm body to cremation, asks Dr Mitsunobu Yoshii, a neurophysiologist from Japan?

We might also ask ourselves this question. Would we lower a daughter or sister, declared "brain dead" and connected to a breathing apparatus, but with a beating heart and warm, soft body into a grave and then throw the dirt over her. Probably not. Yet transplant promotion agencies suggest we hand over relatives to surgeons who will perform multiple organ harvesting while the donor is in the same condition.

Consider this conundrum.

A person with a knife runs into the hospital intensive care ward and stabs the same “brain dead” woman through the heart. Blood sprays over the bed, her body convulses in pain, circulation stops bringing on a complete death. Would we call this insensitive act the abuse of a dead body or murder? Our innate feelings might be that it was murder though transplant coordinators would claim body abuse.

Two Types of Death Depending on Donor Status

A key feature of the transplant industry is the need to de-humanise the donor. As described more fully in Chapter 14 the status of the dying organ retainer or organkeeper descends slowly from “the patient” to “the deceased” to “the corpse” and finally as “the cadaver”.

In contrast, the status of the organ donor descends with lightning speed going from “the patient” to the “heart-beating cadaver” immediately a doctor declares brain death.

Staff continuing to treat the “heart-beating cadaver” as a living entity are ridiculed by hospital bureaucrats and harvest promoters yet the same behaviour to an organ retainer would be acceptable.

Anaesthetists using anaesthetic to stop possible pain during harvesting are ridiculed and derided and may even face professional sanctions.

Two Types of Patients

As early as initial hospital admission head injury and stroke patients are categorised into two types of patients, those who are donors and those who are non-donors. Medical bureaucrats may deny it but prospective donors are watched with a view of protecting their worth as a parts source. When the patient’s

condition declines doctors continue treatment but keep in mind the value of the harvestable organs. The donor patients may get treatment aimed at protecting their harvestable organs while organ retainers may receive a superior treatment designed to heal the damaged brain. Thus we have two types of patients. Those who require healing treatment and those who are to be maintained for spare parts.

How Happy Are Organ Recipients With Their Lives?

The "happy transplant recipient" stories promoted by the donation agencies are rarely true. To believe that organ recipients are so joyful requires an ignorance of the processes and results of transplanting – an ignorance the donation agencies want to maintain.

The internationally noted Canadian cardiac surgeon, GM Guiraudon, has estimated that,

"...approximately 20% of those heart recipients will show considerable improvement of symptoms, but 20% would die within one year and the remaining 60% barely survive in a prolonged state of misery."[92]

Also reported is that,

"...33% of cardiac transplant patients showed signs of depression" while "wound pain continued to bother a majority of patients for prolonged periods."[93]

Humans Preying on Humans

The image of bright children being saved from death through the transplant of a vital organ from an older donor creates a warm impression. The reality is that transplanting is done in very few children and most child survivors of heart, lung and liver transplants are shockingly unhealthy and unnatural in appearance. One could ask whether it is an act of kindness to subject children to these ordeals.

Most organs go to adults over forty years of age and many to those above sixty and who, one might suggest, profit little from the transplant.

One major transplant into a sick old patient, even with government funding, may soak up their total estate that took a lifetime to accumulate. This is especially true in the United States and countries without national medicare programs where ability to pay often determines whether a patient gets an organ or body part. Thus it has been said organ transplant technology is the pillager of estates benefiting the industry rather than the customer.

Heart transplants were first hailed as a lifesaving procedure, but the industry has descended to less crucial medical procedures including cosmetic surgery that has, perhaps, become the bigger illness itself. This secondary body products industry caters to those with wealth, neurosis and vanity rather than for lifesaving procedures.

One might question the value of transplanting into many middle aged or older patients who have ruined their kidneys through diabetes, a scourge often caused

by eating too much fat and sugar, not getting enough exercise and from hypertension. Others ruin their kidneys and livers through sedentary living and high consumption of alcohol and prescription drugs.

For example, common prescription and supermarket drugs including those containing acetaminophen x128 are still causing liver and kidney failures. Paracetamol may cause acute liver and kidney failure resulting in death or need for a transplant.[94]

Showcase Medicine versus Practical Medicine

A young Australian man from Adelaide was emptying a compressed gas cylinder with his teenage brother in their back yard during a still night. The gas cloud slowly drifted into the pilot light of an outdoor water heater. The cloud exploded resulting in 40% burns to the teenage boy who later had a heart attack and still suffers memory problems. Treating his injuries required skin grafts. His brother and father agreed to be donors, underwent full anaesthetic, and a portion of their outer skin was removed and grafted on to the burned boy. The point here is that the surgical industry manages its costly, high profile glamour transplants, with doubtful results, but can't manage a useful skin bank despite the relative ease of removing it from fully dead donors who had signed consent cards while living.

Equity and Who Gets The Body Materials

When a person signs the organ donor card or electronic database there is an assumption that those most desperate and best able to regain health will receive these organs. Few donors would like the idea that their donation would be snapped up by those with power or wealth.

Most governments in affluent countries pay for kidney transplants from general taxation revenue. Yet for other organ and body part transplants the criteria of having plentiful post-operative care and housing is crucial to being approved for a transplant. This begins to edge out the poorest candidates.

But it is the distribution of body parts and products not vital to maintaining life where the major injustices occur. This situation is partly due to government hospitals having long waiting lists for free, non-emergency surgery while people with expensive insurance enter private hospitals immediately. This means those using skin, bone, ligaments, tendons, hormones and fascia are from the richer classes while the participation of the poorer people is increasingly limited to being donors.

This situation has been prevalent in the United States for decades but has only recently come about in Australia and other countries where it is introduced by raising subsidies for private hospitals and insurance companies while reducing funding for government medical services.

The former United States vice-president, Al Gore, had a bill introduced in the US Congress to ensure that all organ transplants were safe, readily available and distributed fairly. Lobbying by the Lions Clubs of America changed the bill.

They forced the bone, skin and tendon provisions to be taken out, which retained the status quo of distributing donated body parts and products according to the ability to pay rather than need.

Ghoulish Nature of the Act

The ghoulish aspect of waiting for an organ is courageously examined by Melbourne writer, Inga Clendinnen, who received a liver transplant and noted the thrill of the patient awaiting an organ upon hearing an ambulance siren on public holidays.

Japanese cardiologist and academic, Dr Yoshio Watanabe, says that patients have been quoted as confessing to wishing donors an early death.

Japanese sociologist T. Awaya describes the trend: "We are now eyeing each others' bodies greedily, as a potential source of detachable spare parts with which to extend our lives" [95]

And he somewhat optimistically calls it a form of "social" or "friendly" cannibalism.

Transplant technology has opened a Pandora's box of cannibalism where healthy people cringe when a relative develops kidney disease. Twins are particularly prone to being a kidney bank for each other whether they want to or not. This Pandora's Box is driven by the technology and also by medical staff who are excited, even addicted, with new surgical techniques. An American nurse working for thirteen years in the industry reports,

> *Once we were doing a kidney transplant. The patient was on the table and the doctors were scrubbing their hands. I went into the scrub room for something or other and I overheard the doctors say this. " It's three hours of fun for us, five years of misery for the patient." These doctors love operating. It's a passion for them. I guess if you are the patient, you would rather live five years in misery than the alternative, death. But something just seems wrong about this to me. Despite what people think, transplanting organs is not the cure-all that it's made out to be.*[96]

The Hospital As A Place Of Refuge

Transplant hospitals are like a garage you take your car for repairs then discover they are operating an auto wrecking business at the back and suddenly they are pressing you to scrap it for parts.

The training and introduction of hospital and organ agency staff to target relatives of brain dead patients reduces the feeling of protection one feels within a hospital. It is, perhaps, taking advantage of people when they are distressed and vulnerable. Dr David Hill notes:

> "It would also seem that relatives confronted with the sudden trauma that accompanies a mortal accident are in no position to give rational consent to those who have total control, to whom they are in great

> debt for the treatment being received and who, it may be feared, might be displeased by a refusal. Sometimes the shock is such that they are deprived of food and drink and sleep and may be under the influence of sedatives."[96a]

Sociologist T. Awaya may be somewhat optimistic, reducing it to "friendly" human cannibalism, when the effect from this series of medical advances absorb vast amounts of human ingenuity and world resources while producing little in return. As to the effect this new "medicine' might have on the wider society Dr Watanabe says,

> "At present, I am quite certain that most lay people (especially family members of a donor) would be unable to watch the bloody scenes of transplant surgery. Only because they do not see it personally, they do not realise how cruel an act it is and can perhaps console themselves by believing that their loved one has helped some fellow citizens who needed those organs. I am, however, afraid that, once the society takes it for granted that it is acceptable to remove the beating heart, liver, kidneys, small intestines, cornea, many long bones, skin, etc., one by one, from a brain dead person who is still warm and rosy, people will get accustomed to such cruelty, and man's intrinsic sense of guilt that deters bodily injury, murder and mutilation of the corpse may well be lost. If such a change in people's way of thinking is combined with the trend to wish for someone else's death in order to get an organ and live, the danger of organ traffic with increased crime, possible ecological risk of widespread and long term immunosuppressive therapy and so forth, we may well end up with a society full of terror and mutual distrust. Thus, it is our responsibility whether we are going to leave for our descendants a safe, peaceful society or one full of terror and unrest.[97]

The Hidden Cost For Animals

Another hidden cost for the continual development of transplant technology is the need to perform unspeakable acts of research on thousands of chimpanzees, baboons, monkeys and pigs. These acts not only create suffering among animals, but damage human society because people can't openly admit their indirect involvement in such terrible events that are occurring near where they live and work.

Before every surgeon attempts a new procedure he or she must practice this technique on dozens of animals until a degree of expertise has been attained. Then the surgeon tries the procedure on a human.

While researching this subject I've read dozens of books and hundreds of websites and research papers on transplant surgery which contain constant

references to dogs, baboons, monkeys, chimpanzees and pigs being used for ugly surgical and transplant experiments. Even ex-space flight candidates and circus chimps have been used for xeno transplant experiments because they've been trained to behave under stress and their teeth have been removed.[98]

Each new report on improved transplant technology will involve thousands of animals being subjected by humans to transplants from their own and other species. After surgery researchers keep them tied to a bed or table, often with little or no post-operative anaesthetic, then calmly watch, measure and test. When the experiment is over they kill the animals – sometimes with regret, other times with indifference.

While medical researchers may calmly watch the animals endure pain they are not disinterested observers. Almost every scientist doing research is involved in the commerce of biotechnology. Whether a new drug or surgical implant is beneficial to humanity is often secondary. The primary aim is maintaining research grants and inventing profitable new products or procedures for the sponsoring drug company.

For promotional reasons pigs are the prized animals of choice for human transplants despite having less compatibility than primates. They walk on all fours, are too big and have hearts that pump most efficiently while the animal is horizontal. Baboons, chimps, gorillas and monkeys are far more compatible but, despite being like us, they are slow to reproduce and mature. They also require plenty of varied, fresh and expensive foods while pigs eat anything. Pigs breed quickly, suffer less illness and humans tends to dislike them so few care what happens to them.

The public is fed the promotional line that animals, particularly pigs, will be used for transplant purposes, but the contrast between animals and humans is such that animals probably won't be used. The transplant industry will need something more compatible and since humanity won't allow the raising of humans for parts it may seek a semi-human clone. This will require decades of changing laws and mentally conditioning the public to believe that semi-humans don't have souls and aren't sentient. A feature of mental conditioning is an element of fear so the population may be terrorised, one way or another, to acquiesce

Tom FrankenStarzl

Since Tom Starzl's failed drug company funded attempts to transplant baboon livers into humans in 1992 and 1993 experiments have moved to shifting major organs between animal species. We have secret labs harvesting organs from larger animals and transplanting them into smaller ones and vice versa. This creates examples where a larger baboon heart won't fit into a monkey so it will be connected with tubes and sit outside of the monkey, which may even hold it in its arms and understand that its life depends on protecting this alien pumping mechanism. This advance in transplant technology is hailed as an example of an evolving humanity, but rather represents a downward spiral or devolution.

Maintaining Kidney Harvest Rates

The smooth flow of harvested human kidneys is maintained despite increased next of kin resistance and reduced trauma injuries. Harvest protagonists achieve this by reducing the qualifications for brain death, spotting donor candidates before their hearts stop, and by lowering the time periods between hospital admission, brain death diagnosis and harvesting.

Transplant protagonists hope to meet the increased demand for organs by decreasing the rights of injured or disabled patients making it quicker and easier to get their organs. These decreased rights include

a) assumed consent to harvest unless written organ retainer intentions have been stated

b) harvesting "vegetables" whose consciousness is dormant but the brain area which maintains bodily functions is alive and healthy (as distinct from brain dead where the part of the brain that maintains body function is dying)

c) harvesting terminally disabled babies at birth.

These changes will have a corrosive affect on the belief that hospitals are exclusively places of protection. People will increasingly see hospitals as places where humans prey on other humans.

Frankenstein Scenario

We've all heard of these new stem cell procedures promoted by the biotechnology industry. It seems every city in the Western World has two university professors who have begun their own company to market stem cell or cloning technology and need a few million dollars of start-up investment. The story line goes that within five to ten years many major diseases will be a thing of the past and all the professors need is some speculative investment. They invariably claim much interest has been shown from countries all over the world. Oh, and laws and sentiments questioning the ethics of this new science must be relaxed.

Foetal stem cells are obtained from similar technology to in-vitro fertilisation or test-tube babies. The test-tube doctors, using the man's sperm and woman's eggs, will make seven or eight in-vitro zygotes or embryos and plant only two or three into the woman. This leaves a few spares they will chop up for stem cells. Another source is from aborted foetuses. Many foetus cells are still at a primitive state and can develop into cells with specific characteristics and functions to those organs or tissues with which they are placed.

This means foetal stem cells injected into certain areas of the receiving animal or human can be coaxed into becoming gut, cartilage, bone, muscle and neuronal cells. Best experimental results are gained when foetal stem cells are obtained from the same species being treated. This means human foetal cells obtained

from abortions can be used to rejuvenate the brain cells of Parkinson's or Alzheimer's disease victims. The Frankenstein scenario isn't the procedure but the fact that five foetuses are required to treat one patient and the treatment isn't permanent. The product of abortions may then become a crucial component of medical procedures and the reasons for abortions may be subverted to biotechnology interests.[99] Then we may be forced into maintaining production of aborted foetuses just to feed the medical technology industry.

Humanity Travels Full Circle

Have we have gone the full circle from primitive, Stone Age cannibalism to high technology cannibalism? Cannibalistic interests now dictate government legislation and employ promoters to visit schools and indoctrinate children with ghastly practices disguised as images of benevolence. We are descending socially to where we view a seriously injured person similarly to how dogs in a starving pack gaze at an injured, bleeding dog. They appease their own need of hunger by attacking and eating the injured animal. Or like rats when confronted with a new food, which might be rat poison, force the lowest status rat to test it. The other rats then wait to see if it dies.

Human families are now reacting differently to sick members. We are seeing a guarded reaction, particularly from the lowest status member of families, when another member suffers kidney failure and goes on dialysis. There may be subtle hints implying that by donating a kidney the lowest status member, a person perceived as somewhat useless, can finally do something worthwhile to repay all the help he or she has received from the rest of the family. This is an encroaching, disguised cannibalism similar to that found in the animal kingdom.

It is ironical the human race has developed this new transplant technology, thinking it was lifting us from the semi-animal to a more advanced human state, and then discovering we are going the full circle. We are descending not just to the level of primitive humans but also to that of the unconscious beast. We can mask body harvesting with soft-spoken coordinators and closed-door surgery but we are descending into a cannibalistic society. It remains to be seen where ideological and organisational resistance to this trend will arise.

End Notes and Appendix

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2. *Nilges, R.G. et al.* ***Beyond Brain Death****. Harvard Medical School Ad Hoc Committee to Examine the Definition of Brain Death*

2a The file containing brain death testing procedures is at http://www.anzics.com.au/files/brain_death_organ_donation.pdf and the home page is http://www.anzics.com.au/contact.htm

2b **Dr Peter Doyle**, British Department of Health, in personal correspondence to the author

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4. ***Guardian Newspaper****, United Kingdom. Sarah Boseley, Health Correspondent. 19 August 2000 www.guardianunlimited.co.uk*

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10. ***David Wainwright Evans****, former cardiologist at Papworth Hospital, Cambridgeshire, United Kingdom. Personal correspondence to the author.*

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*Kimbrel, S. **The Human Body Shop**. The Engineering and Marketing of Life**,** Japanese translation by S. Fukuoka Tokyo, Kagaku Dojin-sha 1995*

13. *Young & Matta Editorial. **Anaesthesia** 2000;55;105-6 Correspondence Anaesthesia 2000 55;695-6*

14. *Coimbra CG (1999**) Implications of ischaemic penumbra for the diagnosis of brain death**. Brazilian J Med Biol Res; 32:1538-1545 Study available at www. epm.br/neuro/brdeath.html*

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17. *Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death**. Kluwer Academic Publications, London, United Kingdom. 2000*

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32. ***Australia New Zealand Organ Donor Registry (ANZOD)** Annual Report 2000, editors Karen Herbertt and Graham Russ, ANZDATA Registry, Queen Elizabeth Hospital, Woodville, South Australia*

33. *Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death**. Kluwer Academic Publications, London, United Kingdom. 2000 p 256*

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39. Personal correspondence with the author. The writer has not given permission for her name to be printed.

40. *Deng, Mario C., **Effect of receiving a heart transplant: analysis of a national cohort entered on to a waiting list, stratified by heart failure severity** BMJ 2000;321:540-545 (2 September,2000), Available at British Medical Journal web site at www.bmj.com/cgi/content/full/321/7260/540*

41. ***Dr David Wainwright Evans**, former Cardiologist, Papworth Hospital, United Kingdom, Personal correspondence with the author. Dr Evans says, "The "hunger for scarce resources" has, indeed, deprived many worthy citizens of the chance of useful extension of life via the tried and tested surgical procedures - valve replacements, coronary bypass grafts etc. - which units like ours at Papworth were set up to provide. Three such patients died in one month for lack of operations which, but for heart transplants, they would have received while with us; as it was, they were sent out to await the availability of facilities (particularly ITU beds) and perished ere they could be re-admitted. In one 18-month period we lost 14 patients similarly."*

41a The Australia and New Zealand Dialysis and Transplant Registry (ANZDATA) *Queen Elizabeth Hospital, Woodville, South Australia* http://www.anzdata.org.au

42. ***Orange County Register Newspaper**, California. U.S.A. Body Broker Series. April16-20, 2000. www.ocregister.com/features/body/index.shtml*

43. ***Orange County Register Newspaper,** California. U.S.A. Body Broker Series. April16-20, 2000. www.ocregister.com/features/body/index.shtml*

44. ***Glaxo-Wellcome** (now known as Glaxo-Smith-Kline) has funded the Victorian Donor Registry in Australia with $400,000. Fujisawa, who manufacturer Tacrolimus under the tradename Prograf, fund production of **What Every Patient Needs To Know**, a publication of the United Network for Organ Sharing (UNOS) the world's largest organ allocation and transplant promotion organisation. UNOS holds the government contracted monopoly on organ allocation for the whole of the United States. The booklet includes finding a transplant team with a high survival rate, maximising government and insurance payments and, if you don't have enough money, asking for donations from churches, service groups and contacting media to run sad case stories and running charity fundraising campaigns with you as the principal beneficiary.*

On page one it says, "UNOS gratefully acknowledges Fujisawa HealthCare, Inc. whose generous education grant made possible the

production of What Every Patient Needs To Know." But why does Fujisawa so kindly provide funding for UNOS, well, the booklet doesn't mention this but UNOS owns a shadow organisation called the UNOS Foundation which itself owns something called Transplant Informatics Institute run by UNOS staffers which analyses and sells organ network data to guess who, Fujisawa HealthCare which wants their product, Tacrolimus, to replace the current favourite, cyclosporin, which is produced by rival drug company, Novartis.

Drug companies sponsoring organ allocation and donor promotion organisations isn't unusual, but perhaps the dubious aspect is UNOS thanking Fujisawa thus creating the impression it is a gift rather than a commercial trade agreement between businesses.

And what else does the booklet tell us? Cyclosporin, the most popular anti-rejection drug made by rival company, Novartis, is merely "A drug" which suppresses "the body's defence system" while the less popular Tacrolimis (Prograf), produced by Fujisawa, is "A powerful immunosuppressant" which "turns down the body's immune response" It pays to give money to UNOS. (see page 8 and 10 of the booklet)

45. ***Orange County Register Newspaper,*** *California. U.S.A. Body Broker Series. 16-20 April, 2000.*
    www.ocregister.com/features/body/index.shtml

46. ***Orange County Register Newspaper****, California. U.S.A. Body Broker Series. 16-20 April, 2000.*
    www.ocregister.com/features/body/index.shtml

Another product is Restylane; a non-animal stabilised Hyaluronic Acid, which is injected into the lips. It is made from culturing in-vitro cells removed from the swollen joints associated with arthritis. Cosmetic technicians inject Restylane into the face causing arthritic swelling, which removes wrinkles. It can also be used to swell thin, cruel lips making them look pouting and attractive. It costs $395 and lasts one year. Yet another wrinkle reducer is made from botulism. It paralyses the facial muscle so the customer can't smile or grimace nor produce laugh lines.

These products are advertised in glossy magazines devoted to the subject of cosmetic surgical procedures and include bum implants for men who want their buttocks to stick out. Much of the transplant industry feeds neurosis and wastes resources that should go to preventative medicine and medical help for poorer people of the world. Who would want a bum implant, anyway?

47. ***Orange County Register Newspaper,*** *California. U.S.A. Body Broker Series. 16-20 April, 2000.*
    www.ocregister.com/features/body/index.shtml

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48a. ***Adelaide Advertiser Newspaper****, Adelaide, South Australia, Australia. 7 January, 2002*

49. *Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors.* ***Beyond Brain Death.*** *Kluwer Academic Publications, London, United Kingdom. 2000 p 163*

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Appendix One

Dr David Wainwright Evans

Cerebral angiography is an old and quite dangerous technique for demonstration of blood flow in the major arteries and veins inside the skull. It involves the injection of a radio-opaque contrast medium (often known colloquially as "dye") into the carotid - and, maybe, the vertebral - arteries. This contrast medium is **not** radioactive. Its presence in the intracranial vessels can only be ascertained by taking X-ray pictures from several angles. It is a relatively insensitive technique because the thick bony skull poses problems for X-ray imaging and, crucially, because quite a lot of contrast has to get into the intracranial (i.c.) vessels to guarantee a "shadow" on the film. It is, therefore, easy enough to see things like displacement of well-filled vessels (e.g. in cerebral tumour etc.) but difficult or impossible to rule out some blood flow in some parts of a generally swollen brain. It is entirely possible for an angiogram to be reported as showing no evidence of i.c. flow although there may be just enough oxygenated blood getting through to keep brain tissue in some areas alive (cf. Coimbra's "ischemic penumbra"). For these reasons - and because the technique may exacerbate the brain damage or even cause fatal collapse in the X-ray room (shades of the apnoea test ….) - cerebral angiography has never been a popular investigation where so-called brain death is concerned, even in those centres where the technique is readily available.

By contrast (no pun intended!), *radioisotope studies* **do**, as their name suggests, use radioactive tracer substances in their attempt to detect intracranial blood flow. This, also, is a relatively insensitive means of demonstrating minimal flows - for many of the same reasons - but it is much less dangerous (though not generally available). Doppler flow studies, which use ultrasound, are even safer but still less reliable. Some centres use these techniques, chiefly in research studies aimed at justifying the clinical diagnosis of brain death, but they have never been popular here and are not required for the diagnosis of "death for transplant purposes" on the basis of the Department of Health's "Code of Practice". Were they to be carried out on some of those certified "dead" under those rules, it is exceedingly likely that some would show evidence of persisting i.c. blood flow - an additional and very powerful reason **not** to use such "confirmatory techniques".

Appendix Two

Dr David Wainwright Evans

We are talking about severe, usually traumatic, brain injury. There will be parts of the brain which have been destroyed by the injury itself, by the extravasation of blood or by total deprivation of blood supply - due to rupture or occlusion of critical vessels perhaps but also because the blood supply to the brain as a whole becomes compromised by the rise in intracranial pressure (due to the brain swelling/oedema which accompanies the initial trauma). The "global ischemic penumbra" of which Coimbra speaks is that potentially very large part of the brain (hence the term "global") which has not been destroyed by the interruption of circulation but is nevertheless so severely compromised by it (i.e. getting such an absolutely minimal trickle of blood - just enough to keep it alive but not enough to allow it to function) that it shows no sign of life (is functionless for the time being) and will die if the circulation is not restored very quickly or if it is not somehow protected from the effects of anoxia while the supply of oxygen and nutrients remains inadequate. There are means of protecting this apparently functionless and severely compromised brain tissue from further ischemic damage during the crucial few hours after the index injury. They include drugs and hypothermia and they work by limiting or actively reducing the swelling (so that some blood can get into the skull against the elevated intracranial pressure which tends to keep it out) and by reducing the demand for oxygen and nutrients while the blood flow is critically inadequate. This latter is the way in which moderate hypothermia is thought to work. Whether or not it can really achieve much salvage is still a matter of debate. The most recent studies of which I am aware indicate that it is the intracranial pressure which is of paramount importance and that attempts to increase the perfusion pressure do not help. It looks as if the emphasis should be on measures to reduce the "reactive oedema" and to keep the brain reasonably cool (and perhaps "sedated") during the early hours in the hope that circulation will be restored to the "penumbra" brain tissue in time for it to regain function and viability.

To sum up : The management of severe brain injury in its early phase is dominated by (1) attempts to reduce swelling of the brain within the rigid skull so that as much blood as possible may get in against the rising intracranial pressure which is "trying" to keep it out, and (2) attempts to minimize the demand for oxygen and nutrients of those (perhaps large) parts of the brain which might survive if they could be protected from handing in their cards before the swelling goes down and an adequate blood supply returns in consequence. The measures used in pursuance of (1) include drugs and the prevention of hypertension and overhydration. Hypothermia (not *profound* hypothermia, which is cooling to very much lower temperatures for different purposes) is favoured by some in pursuance of (2) but many are unconvinced of its value and there is vigorous debate about the validity of the trial findings.

What matters is, as Coimbra says, that all the efforts in the early hours be made with the purpose of preserving as much compromised brain tissue as possible. The details of management will (properly) differ from centre to centre - and in

due course consensus may emerge. That is the way genuine progress is made. What should be said is that the treatment of severe head injury should be optimised to that end, in the critical early stages particularly. That means that potentially harmful procedures (such as apnoea testing, which can cause lethal reduction in the perfusion of severely compromised tissue in the "penumbra" regions) must be avoided. Likewise overhydration, hyperthermia etc. The avoidance of measures which might exacerbate the brain damage, by whatever mechanism, is at least as important in the optimal management of these patients as the deployment of specific therapies. It is just such optimal management (aimed at maximizing salvage and therefore prospects of recovery) which is so conspicuously absent when the patient is regarded as a potential organ donor - perhaps from the first.

