

The **Nasty Side** of
Organ
Transplanting

*The Cannibalistic Nature of
Transplant Medicine*

Norm Barber

Third Edition 2007

“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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Foreword to the Third Edition

It was Professor Geoffrey Dahlenburg from the South Australian Organ Donation Agency who got me interested in organ transplanting. He said transplant coordinators would no longer be accepting a "soft no" from relatives who expressed reluctance 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

That was nine years ago. In 2005 Australian state governments tightened the screws further. Relatives can no longer veto next of kin's organ harvesting unless they have "sincerely held beliefs". I have not been able to locate a government representative who will define a "sincerely held belief". Nor will any donation agency say who in the hospital determines whether the belief is sincerely held or not. We have come a long way since Professor Dahlenburg's "softly, softly" approach. Governments have begun usurping family control of their next of kin "brain dead" bodies.

The increased talk of compensating living people in richer countries for "discomfort and travel expenses" while donating a kidney masks plans for organ selling in these nations. Even benevolent donating is under question when the government of New South Wales advises prospective donors: "Remember that is your decision...It's OK to say NO!" One says, "no", when responding to a question, but not when making an unsolicited donation. The hard end of this solicitation to donate a kidney is when relatives take legal action in an attempt to force a person to "donate" a kidney or organ part.

The revival of non heart-beating vital organ donation sounds initially like a return to the good old days when organ removal began well after the donor's heart ceased beating. The new version is different where organ removal begins without even the fictitious "brain death" diagnoses. The patient is chilled and perfused with potentially injurious harvesting drugs while still being treated therapeutically in a hospital. Life-support (specifically mechanical ventilation) is removed and as little as two-minutes after cardiac arrest the patient is classed as "dead". Surgery to remove his organs then begins, even though cardiopulmonary resuscitation might very well be successful at that stage. It may, indeed, be performed - for the sake of the organs - and we may then have the strange scenario where the heart is still pumping oxygenated blood throughout the body although it is declared a "corpse" (as is the case when organs are taken after a diagnosis of "brain death").

Even more horrible is the failure of the heart to stop when the ventilator is disconnected. The patient is then wheeled back into intensive care, put back on life-support and treated for the new problem of being full of harvesting drugs. Later, if recovery isn't evident the same process repeats itself. Needless to say government health departments are reluctant to speak about this process.

I've continued asking questions and the angelic tale of post-mortem benevolence increasingly resembles a cannibalistic saga. Government employees pressure families in their hour of grief to hand over gravely ill, brain-injured relatives for harvesting. Legal and medical definitions of death are increasingly avoided as the hypothesis of "brain death" becomes technically indefensible. There is too much difficulty defending why surgeons can saw and cut into patients with healthy still-beating hearts yet 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 three different forms.

The first type of harvesting is of tissue from the truly dead bodies of consenting adults who made informed choices. They are given full healing treatment while alive and at a decent interval after death their body materials are taken to be used for effective healing purposes. Bone, skin, eyes, tendons, veins, heart valves are characteristically removed from these bodies.

The other extreme of harvesting - of organs still viable enough to be able to function for years in a different body - begins while the donor is still alive though declared "brain dead". The patient's heart continues beating; the body is warm and blood flows throughout the organ removal procedure. It's the harvest surgeon's knife that causes death.

The third form of harvesting uses non-heart-beating donors who are dependent on life-support measures - typically mechanical ventilation - but haven't met the criteria by which they might have been declared "brain dead". After pre-treatments in the interest of the wanted organs, but which may be injurious to their owners, their life-support is terminated in an operating theatre where everything has been made ready so that organ removal can begin almost as soon as their hearts stop - within a very few minutes of the onset of cardiac arrest in some cases. While those short periods of circulatory arrest are quite inadequate to ensure that irreversible destruction of the nervous system is under way - indeed, resuscitation to the pre-arrest state would be possible in most or all such cases - the removal of their organs does complete the dying process. That looks like an orchestrated "knock them on the head" donor death.

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 as nearly as possible in perfect health from warm, soft and still reactive bodies to make the transfer of organs worthwhile. Their initial ethical and legal problem in the early days of transplanting was that this process constituted murder, (and may still do so).

Christiaan Barnard performed the world's first human heart transplant in December 1967 in South Africa. He proved that heart transplanting was feasible but the operation was not a success. The donor, Denise Durval, became an instant celebrity after being hit by a car while leaving a junk food store. Brain tissue leaked from her ear and Denise was, for a brief flicker in eternity, the most famous woman in the world. Her father ensured her fame by allowing surgeons to remove her heart for the world's first human heart transplant.

Louis Washkansky was a Lithuanian Jew from the town of Slabodka who had been deported to the Crimea when the Russians accused the Jews of being German spies. Louis later moved to South Africa and worked as a grocer then developed a bad heart. When the car knocked down Denise he was desperately living each day at a time and waiting to become the world's first heart transplant recipient.

He was on the operating table when hovering surgeons next door had opened up Denise and were eagerly awaiting her heart to stop forever. But it wouldn't stop.

Christiaan Barnard was worried the slow process of death would ruin Denise's strong heart. Her brain was badly damaged and some bodily functions were failing and he thought the heart in particular would suffer damage during this prolonged collapse.

When a person suffers catastrophic brain damage body temperature, blood pressure control, renal and endocrine function, and a variety of other processes progressively malfunction as the body dies. The heart is particularly vulnerable to damage during this process.

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 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 beat strongly and pumped lifesaving blood throughout Washkansky's body, but he died eighteen days later, with extensive bilateral pneumonia.

The autopsy of Louis Washkansky's body showed that the transplantation of Denise's heart had been technically perfect and, despite the patient's death, surgeons around the world rejoiced at the world's first successful human heart transplant. But there was still that problem of the slow dying process. So the second cardiac transplant, less than two weeks later, used a heart which was still beating right up to the time of its removal from a patient who was expected to die very soon from his subarachnoid haemorrhage.

To avoid the legal and ethical problems which would otherwise have been invited by operating on a dying patient to remove his heart while it was still beating naturally and maintaining his bodily circulation, his physician was persuaded to pronounce - and presumably to certify - him "dead" before the procurement surgery commenced. The grounds upon which he diagnosed death are not clear. There were no "brain death" criteria in use for that purpose anywhere in the World at that time. In an account of the crucial part he thus played in that second heart transplant, the greater success of which sparked worldwide enthusiasm for the procedure and secured its future, the physician pleads political pressure, perhaps still searching for some reason to understand his atypical failure to observe the dictates of conscience at that very difficult time.²

An Invented Death

The Harvard Medical School came to the rescue by setting up an Ad Hoc Committee to Examine the Definition of "brain death" - or, rather, to invent a new definition of death and give it status.

This committee of thirteen neurologists, neurosurgeons, lawyers, philosophers and an anaesthetist decided that death could be proclaimed if a ventilator-dependent patient failed to respond to a series of reflex tests. They were called the Harvard Criteria for the diagnosis of "brain death". This allowed a brain injured patient with a healthy, beating heart and fully operating renal and endocrine system to be defined as dead, just like a cold corpse.³

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 death was to the everlasting pleasure of transplant surgeons, who could now declare patients dead before their hearts stopped, remove their vital organs and no longer worry about a murder rap.

The fact that the donor's body, if mechanically ventilated was digesting and absorbing food, urinating, defecating, filtering blood through the kidneys and liver, healing itself when injured, maintaining body temperature (and, perhaps, a foetus in utero) meant nothing.⁴ He or she was declared "brain dead" and operated upon to remove their heart while still in that condition. This killed the

donor, but legally it was okay. What one day was murder was the next day a brilliant surgical technique.

Combined with the relative success of Barnard's second 1967 heart transplant - into Philip Blaiberg, who lived through eighteen months - this legitimisation of "brain death" provided the impetus for the rush towards mass transplanting. It wasn't until the immunosuppressant, Cyclosporin, was introduced in 1983, that the transplant industry received another such boost.

The "Brain Death" Test

Prime candidates for organ donation are those suffering catastrophic brain trauma, with haemorrhage and swelling caused by car and motorcycle smashes, gunshot or knife wounds to the head or stroke victims. In these instances an artery inside the head is broken and surging blood spills into the skull but with nowhere to go. Pressure builds up in the brain and may even force the brain stem downward. Circulation through the brain slows and its cells run out of oxygen resulting in brain damage and eventual death.

Heart attacks, heart failure, asphyxiation from smoke inhalation or strangulation that reduce or stop oxygen rich blood circulating in the brain, causing global cerebral ischemia, can also make someone an organ donation 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 ventilate the patients' lungs until they reach the hospital.

Patients arriving in this condition alert hospital staff to two possibilities, the first being to aid recovery from injuries and, secondly, that they have a potential candidate for organ harvesting. Hospital staff check the organ donor register and personal belongings for donor registration. Transplant coordinators 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, doctors perform the first series of "brain death" tests and, if this is indicated, then a few hours later another, final, series of tests is carried out.

However, there are varied protocols around the world, rarely enshrined in legislation, so doctors devise their own methods to determine "brain death". For example, the United Kingdom Code of Practice requires two doctors to be involved but doesn't specify time periods between tests so repeat testing may be a formality.

The Australia New Zealand Intensive Care Society (ANZICS) recommends a series of tests but doctors haven't any obligation to use them. The Society refused to provide their recommended criteria for "brain death" testing demonstrating perhaps their disdain for public education. They later published these, including the controversial apnoea test, on their website.⁵

The Test for Death Begins

Relatives are discouraged from observing "brain death" testing in case they're sickened by its physical rigour and the appearance that their loved one is being harmed.

A strong light is shone into the patient's pupils. They should shrink in size and failure to do so may indicate brain injury. This won't be done if the eyes are full of blood. The doctor 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 touched with a cotton-covered prod and painful pressure is applied to the eye-socket to check for reaction. Failure to react may indicate brain damage. Doctors are warned to avoid damaging the cornea during this testing.

A catheter is pushed down the windpipe to provoke a cough reflex, this being indicative of brain function. A probe is stuck into the mouth to check for gag reflex. The doctor turns the head sideways and pours ice-cold saline into the ear. This should provoke deviation of the eyes. If it does not, this indicates loss of function of another neural pathway in the brain stem.

Painful stimuli are applied to various parts of the body to look for responses involving the cerebral nerve network. Reflex responses which can be explained as purely local are no longer regarded as significant.

Electroencephalography is an essential element in many protocols and displays electrical activity in the brain. A "shower cap" is placed on the patient's head and presses metal electrodes against the scalp. The absence of recordable electrical activity - "electrocerebral silence" - affords evidence of cessation of function in the more superficial parts of the brain, particularly the cerebral cortex. But it does not exclude continuing activity in the deeper parts of the brain and cannot, of course, distinguish between temporary and permanent absence of function. The test doesn't cause harm to the patient.

Some countries use cerebral angiography where doctors inject radio-opaque contrast medium ("dye") into the bloodstream and X-Rays observe the flow of blood to the brain. A lack of dye movement to the brain indicates lack of circulation and possible "brain death".

Radioactive tracers are injected into the bloodstream during the Radioisotope Study. These radioisotopes emit radiation and their presence is detected by devices like Geiger Counters that respond to radioactivity. The flow of blood to the brain is indicated by the movement of radioisotopes inside the skull.

Some further comments on cerebral angiography and radioisotope studies may be found in Appendix One.

Many methods (30+) of diagnosing "brain death" are used around the world, none being universally accepted as sufficiently stringent or reliable for the purpose of certifying death on neurological grounds. There are, in fact, so many variants that they obviously do not all define the same clinical syndrome. "Brain death", as clinically diagnosed, is clearly not a true entity. That being so, the

highly relevant conceptual arguments about any novel form of diagnosing death on such grounds do not arise for consideration.

The Apnoea Test

The Doctor Disconnects the Breathing Machine

The Apnoea Test is the final test for patients not responding sufficiently to previous tests. The doctor turns off their ventilator, which has maintained their breathing, and leaves it disconnected for up to ten minutes.

Oxygen is pumped down the trachea to minimize oxygen deprivation while the ventilator is no longer inflating and deflating the lungs. During the disconnection, the carbon dioxide tension in the bloodstream rises - because it is not being "blown off" by the unventilated lungs - and will trigger spontaneous breathing efforts if the respiratory centre in the brain stem is still sufficiently responsive (alive). If not, and the patient fails to begin breathing when the CO₂ tension has reached the prescribed level, the penultimate "brain death" requirement is satisfied. The ventilator is then reconnected and mechanical breathing resumed until such time as the test is repeated.

Every effort is made to ensure that, during this test, the patient does not become crucially short of oxygen - which would risk damage to wanted organs - despite the fact that a very low level of oxygen in the bloodstream (anoxaemia) is a more powerful drive stimulus to the brain stem respiratory centre than high CO₂ levels. Patients who have not shown breathing efforts when subjected to the latter may yet exhibit breathing efforts - "agonal gasps" - if the ventilator is left disconnected so that anoxaemia develops.

Apnoea testing is the Achilles heel of all "brain death" protocols - too dangerous to use on a patient who is still, by common consent, alive at this stage. And, even so, not stringent enough to diagnose irreversible loss of the capacity to breathe spontaneously.

Second "brain death" Test

A second series of "brain death" tests is undertaken prior to harvesting. In Japan the second doctor waits six hours, in Spain twelve hours with adults and twenty-four hours with children. Australians wait two hours. Two doctors have to certify death in the United Kingdom but they're not required to undertake two series of tests sequentially. In many cases the second doctor is simply an observer, watching the other doctor perform the tests.

A patient failing to respond to the second test is certified "brain dead". The patient loses legal entity status, has no human rights and is called the "heart-beating cadaver". The ventilator is re-started and the body, though legally dead, is kept alive on life support until surgeons have been assembled and transplant hopefuls brought to the hospital. This may take hours or days.⁶ All treatment to heal the injured brain will cease and doctors will increase fluid drip and blood pressure, and inject anti-psychotic medications like chlorpromazine to maintain

the organs at the expense of the "dead" brain. The patient may be transferred to a hospital better equipped to remove organs though authorities deny this happens.

Various Types of "brain death"

Most European countries and some American states recognise the "whole brain death" criterion 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, have adopted the lesser "brain stem death" criterion. The brain stem is situated between the major part of the brain - the big cerebral hemispheres and the mid-brain - and the top of the spinal cord. It controls some of the automatic physical functions such as breathing and regulation of blood pressure. The concept of "brain stem death" means that part (or even most) of the brain may be alive but if the brain stem is irreversibly damaged then this is considered equivalent to "brain death" which is equivalent to being legally dead which is equivalent to being really dead, or so the logic goes.

Many medical specialists working in the transplant field acknowledge privately the absurdity of the "brain death" concept though few state this publicly. One exception is United Kingdom Critical Care Consultant, Tom E Woodcock, who suggests the medical colleges stop equating "brain death" with the death of the patient and start administering anaesthetic to these vital organ donors.⁷

Chapter 2

Donors May Need Anaesthetic

The residual doubts about the donor's health status increase when he or she reaches the harvest table. Let's imagine a twelve-year old girl has been diagnosed "brain dead" after being hit by a car while riding her bicycle. Her body is cleaned, shaved, tubes inserted and she is hooked up to various machines. She is paralysed with muscle-relaxant drugs. The transplant team pretends that this girl is a plain, dead corpse lying on the operating table.

The surgeon draws a clean, deep slice down the middle of her torso cutting through skin, muscle and fat. But then, as the surgery goes on, a strange thing occurs. Instead of lying there inert and unresponsive like a corpse, her blood pressure rises and her heart rate speeds up just as it does in patients undergoing therapeutic surgery - surgery for their own good - when they may be too lightly anaesthetized and feeling pain. In that situation, those are signs to the anaesthetist that a bit more anaesthetic is necessary.

More violent reactions which might otherwise be seen in the excision process are prevented by the preoperative injection of a drug like pancuronium. This prevents her torso jerking and bucking or her arms and legs flailing about. Or her body sitting up on the operating table with outstretched arms in what has been described as coordinated attempts to "grab the knife". Masahiro Morioka describes it thus: "...brain dead patients sometimes move their hands toward the chest automatically and show a praying posture (known as the Lazarus sign)..."⁸

The anaesthetist, if there is one in attendance (as is not always the case these days), may also administer a morphine drip or anaesthetic to prevent possible pain to the donor during surgery, and to assuage their doubts and the distress of other theatre staff. Donation agencies bitterly resent medical staff using anaesthetic because they spend their working lives trying to persuade distressed parents and other next of kin that the patient has actually died.

But many medical experts doubt this.

Professional Opinion

The late Dr Phillip Keep, former 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."⁹

Dr Keep added,

"I don't carry a donor card at the moment because I know what happens." ¹⁰

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 organ removal as if the donor had come in to the harvest room alive. ¹¹ This contradicted the official time of death when the patient was diagnosed "brain dead".

Dr David Wainwright Evans, a cardiologist, formerly of Papworth Hospital in Cambridgeshire, England observed 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." ¹²

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.

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." ¹³

D.A. Shewmon, Professor of Neurology and Paediatrics, University of California (Los Angeles) School of Medicine, says some surgeons feel they are killing the donors. ¹⁴ He was interviewed by the Australian Broadcasting Corporation. ¹⁵

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 W. Evans is also amongst a number of medical professionals who doubt 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."¹⁶

Dr David Hill concurs,

"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."¹⁷

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."¹⁸

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."¹⁹

Chapter 3

The Apnoea "Brain Death" test may kill the patient

The possibility of donors feeling pain during organ harvesting isn't the only problem. One body of scientific research opinion suggests 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"*.²⁰

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 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.²¹

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

This is because tests to establish "brain death" require normal body temperature and removal of ventilator support resulting in increased carbon dioxide levels in the blood. Coimbra shows this combination may be fatal to otherwise recoverable brain cells.²²

Healing Treatments Denied To Potential Donors

Dr Yoshio Watanabe is an academic and cardiologist at the Cardiovascular Institute, Fujita Health University School of Medicine in Toyoake, Japan. He says that applying the 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 donation accelerate brain injury. He cites examples of apnoea testing repeated many times.²³

In one instance, Dr Watanabe says, 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 removed her heart, liver and two kidneys.

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 transplantable. This included drugs that elevate blood pressure, large amounts of drip infusion that "aggravate brain oedema, increase intracranial pressure and accelerate the process of "brain death"". They threatened his wife to agree to donate organs without telling her that the treatment to keep the organs transplantable would increase brain damage.²⁴

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.²⁵

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 the 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 claim the apnoea test has been performed there repeatedly to achieve "brain death" rather than diagnose it.

Organ Donors may be denied protective Barbiturates

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" and making it a disadvantage to be a registered organ donor. A brain injured patient listed as a non-donor or organ keeper may get superior treatment in a hospital trauma unit.

A second problem is that barbiturates and other reflex depressing drugs may already be present in the donor candidate. This might result in sluggish reflexes 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."²⁶

Some further comments about the treatment of life-threatening head injury may be found in Appendix Two.

Back from the brain dead

The difficulty in ascertaining whether a potential organ donor is dead was exemplified in a University of Bonn Medical Center study where 2 of 113 who were initially thought to be mortally brain-damaged defied the fatal prognosis and made recoveries. The study involved neurosurgical patients mostly suffering brain trauma injury (bangs to the head), and intracranial haemorrhage (strokes).

The decisions to terminate further treatment were made after stringent and extensive brain activity testing. Yet despite this, two such “end of life” diagnoses were subsequently reversed and the patients made unexpected recoveries.²⁷

When such misdiagnosis are made despite comprehensive testing, one might also doubt similar diagnoses, in patients identified as organ donors, when those diagnoses are made solely on the basis of “...simple bedside tests (performed) after only a few hours' of ventilator-dependent coma...”²⁸

One might logically conclude that some patients previously harvested for their vital organs could have survived if organ removal hadn't been rushed as Dr David Evans sagely notes:

"The additional test, which saved these two, was the passage of time – one of the most powerful diagnostic weapons available to the doctor, yet one which is almost casually set aside when neurologists are under pressure to provide viable organs for transplantation."²⁹

Professor Coimbra echoes this wisdom with a knell of mourning:

"... a review of the literature shows that some of even the most severely head-injured patients (GCS of 3 or 4, with pupils fixed to light) who are not subjected to apnoea may recover to normal life. Early labelling of these patients as dead (for transplant purposes) during the past 3 decades has diverted medical researchers away from developing novel therapeutic resources that could already have saved many thousands of human lives throughout the world."³⁰

Chapter 4

Organ Rejection

The human body experiences a transplanted organ as a malignant tumour that it tries to kill.

The immune system attacks this alien organ with B cell anti-bodies, sometimes within minutes, and may turn the organ black and blotchy even before surgeons have sewn up the wound. Most patients survive this initial immune attack and there is a brief "honeymoon period". Government public relations consultants may parade the person in front of 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 the alien organ. Transplant coordinators discourage further media reporting because the patient no longer feels well or grateful for the organ.

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

The most popular immune-suppressant is Cyclosporin, produced from a poisonous Norwegian fungus that attacks the immune system by disabling the killer T-cells. Not unexpectedly this poison has side-effects including gums growing over the teeth and increased hair growth everywhere. Some transplant guidebooks even have sections on hair removal. Cyclosporin also causes lymphoma cancer and other deadly diseases no longer suppressed by a healthy immune system.

Cardiologist Yoshio Watanabe adds, "One cannot ignore the fact that Cyclosporin causes hypertension, renal failure and left ventricular hypertrophy in 76% of recipients of any organ."³¹

Two biologically derived anti-rejection drugs are Azathioprine and OKT3. Human blood products are injected into mice, rabbits and other animals whose immune responses produce anti-bodies to kill the human anti-bodies. Lab technicians 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 patient's immune system making it too weak to destroy the transplanted organ.

These drugs plus other anti-rejection drugs like Cortico-steroids, Antithymocyte globulins, Tacrolimus (trade name Prograf and also produced from soil fungus), and Mycophenolate mofetil collectively have shocking side-effects. They include 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 include exaggerated fears, panic attacks, blood and guts nightmares, wild mood swings, bad tempers and hallucinations to the point of insanity.³² Steroids also cause vertebrae collapse and slipped disk symptoms which are treated with painkillers.³³ These are a few of the ghastly contra-indications of anti-rejection drugs.

Organ Recipients get AIDS-like Diseases

The open secret of the transplant industry, and one they choose not to share with the public, is that recipients suffer AIDS-like diseases. These immune-failure diseases are as likely to cause death as actual 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 from a cat, microbes from semi-cooked meat, raw eggs and uncooked dough may trigger a life-threatening disease. It also means recipients can expect malignant cancer tumours because the damaged immune function is too weak to kill rogue cells.³⁴

Clint Hallam and the Thing

Clint Hallam was serving time in a New Zealand prison 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 off his hand and sewed it onto Clint’s stump.

Clint had a strong, healthy body and was initially overjoyed with his new hand 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 also looked 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 became too much: he told the doctors to chop it 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 and no longer requires anti-rejection drugs. He has just one hand but the other one was useless, anyway.

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

Matching Donors and Recipients

The ferocious reaction from recipients' immune systems rejecting a stranger's flesh is minimised by matching blood types and Human Leukocyte Antigen (HLA) tissue qualities. The immune system is less ferocious towards body tissue most similar to itself.

Immunologists also reduce the risk of immediate rejection by dosing the recipient's immune system with anti-rejection drugs prior to transplant. They adopt a third precaution by avoiding transplanting an organ that has similar antigens to any material transplanted previously into the recipient. This includes blood transfusions because the immune system is already sensitised to these antigens and forewarned and forearmed against them. Sort of like recognising an old enemy and punching him or her out without delay.

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 by disabling the mother's immune system towards it, but not to other growths or infections. This reaction doesn't damage the mother but her immune system records the initial attack so a transplanted organ shouldn't have the same antigen characteristics as any of her children, miscarriages or abortions. The transplanted organ cannot healthily disable the recipient's immune system as did the foetus.

These factors are considered before an organ is allocated to a patient.

Louis Washkansky

While Denise Durvall's heart was clearly damaged by the terminal dying process, it transplanted perfectly and initially worked well. It was pneumonia that killed Louis Washkansky. Christian Barnard and his team used excessive cortisone, along with pre-transplant irradiation, to protect it from rejection. These 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 reacted by using wide-spectrum antibiotics that killed both good and bad microbes but not the type they wanted to kill. This left his body vulnerable and the infection turned to pneumonia. His lungs clogged up, his feet turned blue and the famous Louis Washkansky was dead eighteen days after his historic 1967 transplant.³⁵

Transplant recipients are never cured. Their lives resemble walking a tightrope between organ rejection and deadly disease. Getting a transplant is exchanging one deadly medical condition for another. Inga Clendinnen says 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".³⁶

"I go to the clinic every couple months. I count my pills, swallow them carefully. I intend to live."³⁷

Christiaan Barnard said, "You cannot stay in the laboratory forever".³⁸ He, like Inga Clendinnen, was a realist and saw beyond the donation agency hype. Most transplant procedures include elements of experimentation and chance, a fact the donation agencies tone down in their promotional material.

Chapter 5

Battle for the Body

The fight between relatives and harvesters over the dead body begins with who gets in first. The person lawfully in possession of the body can authorise the excision of organs and other parts. But who has actual legal possession? In the first instance it is hospital staff. Next of kin can sometimes gain possession by entering the hospital and legally taking 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. This makes it more difficult for next of kin to obtain the body for cremation or burial, or to prevent harvesting.³⁹

Generally, in other countries, to gain possession one doesn't punch out the doctors and grab the body. Possession simply requires stating one's next of kin status: mum, dad, child, spouse, etc and ordering directions regarding the body.⁴⁰ The hospital will send the body to the funeral parlour of your choice or, with your permission, consider it for harvesting. They may claim the body is theirs for harvesting but when push comes to shove the hospital will back down to avoid scandal.

They may also request consent for a post-mortem to examine cause of death, which may be a ploy to remove parts especially if the autopsy consent form contains a tiny clause that authorises body parts donation. You can refuse this autopsy unless death has been sudden, unexpected or mysterious. In these circumstances 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 or other purposes. Some Coroners act strictly, as researchers trying to discover the reason for death while others are sneak thieves acting on behalf of 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 those in 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 is harvested despite not having registered as a donor. The hospital merely needs to say they have no reason to believe the patient was against organ donation. 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.

Transplant coordinators or hospital intensive care staff may jump the gun and persuade grieving relatives to sign consent forms prior to the second "brain death" determination.

Different Versions of "Brain Death"

The procedures used to determine "brain death" vary from country to country. The Japanese require loss of blood pressure to determine "brain death" because the brain stem regulates blood pressure. Normal blood pressure indicates a functioning brain stem and therefore a patient is not considered "brain dead". The United Kingdom rules are different and the same patient considered alive in Japan will be declared "brain dead" and harvested in the UK.

Electroencephalography (EEG)

Electroencephalography (EEG) tests are required in parts of the United States, and some European countries. An EEG displays electrical activity in the brain, evidence which indicates life therein. Spain requires two electroencephalograms 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 electrocerebral silence may be temporary.

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

But that doesn't bother many doctors in Australian hospitals who avoid electroencephalography altogether, claiming it is unreliable and that flickers of electrical activity may be from a decomposing dead brain. Another argument is that an EEG may indicate brain life but that fact is irrelevant. Why? Because it does not affect the prognosis, i.e. because the presence of residual EEG activity does not alter the forecast of death - the final cessation of the heartbeat despite continuing mechanical ventilation - within a few hours or days. So, they rationalise, organ donation might as well begin while the still beating heart perfuses the organs with oxygenated blood. This utilitarian view ignores the uncomfortable fact that we do not know very much about how the brain works and have no means of knowing what persisting EEG activity may be trying to tell us about continuing brain function at some level - even, perhaps, about the persistence of something akin to consciousness (however defined) in some rudimentary form in some remote, untestable, part of that most complex and truly wonderful organ.

One unarguable truth in this debate is that medical experts around the world use a wide variety of techniques to diagnose and certify death on "brain death" criteria. This is not surprising in view of the fact that they can't even agree on what it means to say that a person is dead when his blood is still circulating and his bodily systems are still working, although his brain is so badly damaged that he is almost certain to die - in the commonly understood sense - within a very short time.

Less technological societies determine death differently. They initially consider death as loss of heart beat but keep the body safe for a few days. Their religion may provide rituals to allow the spirit to ascend but for practical purposes it

keeps the body safe until the odour of decomposition becomes apparent. The stench indicates the person is really dead.

Some nations don't consider medical "brain death" criteria valid. Pakistan and Romania don't recognise "brain death" saying the person is still alive. Most Jews don't recognise "brain death" thus organ donation is rare in Israel. Thailand doesn't accept the concepts of "whole brain death" or "brain stem death". Harvesters cutting organs from bodies with beating hearts are charged with murder, which carries a death penalty.

Donation after the Heart Stops Beating

The irony is that viable kidneys are still obtained from donors whose hearts have stopped. "Brain dead" donation is extremely rare in Japan so they remove kidneys from "cardiac dead" people. Graft survival rate is slightly lower at 84.2% at one year and 72.7% at five years. Spain also gets good results from "cardiac dead" donors, even when brought to the hospital already dead.⁴¹ Australia also removes kidneys from "cardiac dead" donors, but hasn't announced this in case someone asks, well, aren't kidneys already removed from dead people.⁴² The Canadian Council for Donation and Transplantation are currently developing protocols for removing kidneys from donors after the cessation of heartbeat.⁴³ It is doubtful this will dent waiting lists due to the difficulty of obtaining consent and the controversy over killing the donor prior to even the flimsy "brain dead" test. (see Chapter 10)

Lungs are harvested from donors in Sweden whose hearts have stopped for one hour alleviating the need to begin lung removal while the donors' hearts are still beating as is presently done elsewhere.

Chapter 6

Aggressive Hospital Harvest Teams

Most people retain a warm view of doctors and nurses cooperating with each other to save lives, but reality is different. Hospitals are stressful places where workers frequently end their shifts exhausted and disturbed. Doctors have higher suicide and drug addiction rates than others. They've been deprived of normal comforts for ten years to complete their medical education. They are driven and ambitious to succeed in a demanding profession.

Transplant technology dangles the possibility of fame and wealth like Christiaan Barnard, Denton Cooley and Norman Shumway — and that mystical lure of eternal life.

Governments and pharmaceutical corporations pressure hospitals and donation agencies to increase organ supply to "save more lives". The drugs companies crave more patients dependent on permanent medication while governments seek reduced dialysis costs. Surgeons and immunologists are the third force desperate to maintain their market share.

When a brain-injured patient arrives by ambulance it isn't just a million dollars worth of surgical activity at stake. It's 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 "brain death" resembles the starter gun at the Olympic one hundred-metre race.

The aggression temperature rises in this boiler room when two medical ideologies collide. Hindering the transplant faction's goals are those tending the brain-injured patients. They 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 conflicting drives as the transplant crowd: pride, ambition and compassion. Their allegiance is to maintaining life at all costs rather than releasing the patient for spare parts. These neurologists, neuro-surgeons, cardiologists and nurses wish to see apparently terminally injured patients walk out of the hospital. Transplant teams see them as impediments to an early diagnosis of "brain death" and subsequent rush to the harvest table.

Transplant coordinators are under similar pressures. They need consent or, at least acquiescence from relatives to 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 or peeking through one-way mirrors at grieving families in the waiting room. They discuss among themselves who can best obtain consent. They're like those street charity collectors who quickly

decide among themselves who will ask: "Excuse me, can I ask you a quick question?"

It is crucial to obtain consent. The coordinator, (or intensive care staff member), faces similar pressure to football players who need to score a goal every game or are relegated to the minor league. They operate under similar motivations of pride, compassion, ambition and a basic desire to stay employed. Coordinators especially will pester and interrogate reluctant relatives until there is outright anger or acquiescence. Other hospital staff may discreetly intervene with coffee or throw the odd harsh glance at the coordinator.

Doctors are increasingly pressured to declare "brain death" earlier than before because waiting lists grow while supply stagnates.

Governments want increased kidney and cornea donation for financial as much as for compassionate reasons. Eighteen months on dialysis costs equal to a kidney transplant that should last seven years. Kidney transplants also improve the quality of life unless surgery or immunological complications turn nasty.

Transplanted corneas are cost effective when they improve the sight of a blind citizen who might otherwise require continuous and expensive care. Corneas don't depend on blood circulation so rarely require dangerous immunosuppressant drugs though there are exceptions where blood vessels infiltrate the transplanted cornea and all hell breaks loose.

And if an aged patient dies due to surgical complications it's a financial boost to the health budget though not a successful social outcome.

Transplant coordinators are under pressure to pursue government objectives, which are to reduce public medical costs by increasing transplant activity.

Doctor Richard Nilges, Emeritus Attending Staff in Neurosurgery of the Swedish Covenant Hospital in Chicago, 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"⁴⁴

Same Day Harvesting and Aggressive Transplant Teams

Doctors previously had a minimum of forty-eight hours to treat the patient prior to "brain death" testing. This gave relatives time to discuss the issue of consent with religious advisers and extended family. Time was allowed for repeated electroencephalograms and, most importantly, time for the patient's condition to improve.

In the era of Day Surgery where patients don't even spend one night in hospital we also 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. Patients may be harvested within 24 hours of suffering brain injury or a stroke.⁴⁵

Doctors worldwide are reporting increased pressure to declare "brain death" before adequate periods of observation, treatment and self-recovery. Transplant surgeons demand other doctors administer drugs and prepare organs for harvesting despite these procedures accelerating brain damage. This changed priority from treatment to harvest preparation shows the paranoia that recuperative treatment may be reduced for prospective donors is not an urban myth.

Dr Richard Nilges 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."⁴⁶

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."⁴⁷

The pressure to declare "brain death" prematurely 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.⁴⁸

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..."⁴⁹

Dr Watanabe reports that a subsequent review of the incident showed that repeated apnoea tests were performed before the electroencephalogram became flat. This is illegal in Japan. Apnoea testing deprives the brain of oxygen and speeds up "brain death". When done repeatedly, one might suggest, it's being done to create "brain death" rather than test for this condition.⁵⁰

Chapter 7

Harvest Time

The rush to prepare the ex-patient and now "brain dead cadaver" for harvesting is interspersed with moments of silence. Hospital transplant staff require relatives to bid farewell to the cadaver or patient with the confusing status before he or she is taken into the operating theatre, still maintained on life-support despite being called dead. The transplant teams are assembled and compatible recipients brought to the hospital.

Transplant staff will have injected heparin, a blood thinner used to prevent blood clotting, into the heart-beating cadaver plus phentolamine mesylate to expand the size of blood vessels. Both drugs may increase bleeding inside the skull but it doesn't matter because the brain-injured patient is considered dead. Medical technicians preserve the organs by putting the "heart-beating cadaver" on a high fluid drip and by injecting drugs to increase blood pressure. These procedures arouse no controversy unless they are done before the patient fails the "brain death" test because they further damage the injured brain.

"Brain death" should also be declared before two catheters are inserted into the abdominal aorta and femoral vessels to flush out the blood from the organs with a cold solution. However, all the above may happen when the heart is still beating, "brain death" not declared and the patient still being treated with a view to recovery.

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.

Removing 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 one is not donated or needed, either put back into the body, thrown away or used for research.

The heart will be removed along 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. The excised 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. It's a real rush because heart and lungs remain viable for about 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.

Transplanting surgeons may remove their particular organ and leave with the picnic cooler box 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 might imagine the nurse sitting in a double seat of an aircraft carefully watching the temperature on an incredibly complex and expensive portable fridge, however, this is not how it is done. 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. A courier may take the organ to the airport where another courier picks it up at the destination.

Hospitals 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, ruined kidney in his van the next day after receiving an unpleasant phone call from the waiting hospital.

Peter Hornsey, the expectant recipient, was waiting in the Queen Elizabeth Hospital in Adelaide. He already had a catheter stuck in his neck and was being dosed 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 home and back onto the waiting list.⁵¹

Reasons for Not Using an Organ

Organs are initially rejected if the donor is considered an infection risk. Disease may be discovered in the body, or the hospital may have fears over the donor's social history. These may include homosexuality, pituitary growth hormone injections, having being a transplant recipient or from recently working as a prostitute. Further rejections may be due to unusual physical characteristics of the organs, tumour presence, and unforeseen damage during the event leading to "brain death" or by surgical error during harvest. An exception to the above is where organs are being used in some nations from donors with a cancer history.

Organ acceptance varies according to 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 States. Australia's standards are uniform between states so an organ rejected in one hospital is likely

to be rejected in another. This means an organ rejected due to quality is rarely offered to another hospital.

Standards in the United States vary so greatly between states and hospitals that a rejection in one place may be acceptable in 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 rejected by even the most desperate hospitals.

Use-By Times

The Use-By time - after removal in good condition from "beating-heart donors" - is five or six hours for excised hearts and lungs. Livers last 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 circulatory 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 from 12-24 hours. Kidneys last 48-72 hours, pancreas' 12-24 and hearts and lungs 4-6 depending on the quality of harvesting, state of organs, preservation and transport.

Use-by times are being extended worldwide and in Australia one heart was kept 8 hours and 11 minutes between bodies while the maximum (cold) ischaemic time for a liver has been nine hours.⁵²

Donors and recipients usually reside in the same city, but organs are still flown to other states. For example, South Australia doesn't have a heart transplant unit so their hearts go to the larger states. The trade-off is that South Australia gets a good deal on kidneys and is a good place for those with kidney failure.^A

Other contributing factors determining who gets an organ are when there is a particularly good tissue match or when an acute patient is sinking fast. An organ may then go interstate despite qualifying patients waiting in the same hospital as the dying donor. Patients awaiting organs may also be left in the lurch if their state owes organs to another state that wants payment from the very next harvest.

^A Edith Pringle, ex-girlfriend of Ralph Clark, former South Australian Deputy Premier, is moving from Adelaide to Melbourne to get on Victoria's heart/lung transplant list. She knows patients near the transplant hospital get priority over those back in South Australia. (She still smokes like a chimney, though).

Skin and Bone Harvesting

Following vital organ removal there is no longer any doubt the patient is dead. This signals the entrance of new dismantling surgeons who continue a less delicate harvest. They're from the Skin and Bone Banks that rent hospital facilities but may get the bodies for free.

Most body parts are salvaged from those who haven't donated vital organs, especially in the United States. They died before retrieval preparations could begin therefore becoming ineligible for vital organ donation. A body must be refrigerated within twelve hours of death to prevent contamination from decay bacteria. In South Australia, a body must be processed for parts within twenty-four hours even if refrigerated immediately upon death.

Some countries don't allow commercial harvesting and the following mostly represents the United States practice, which is the most extensive in the world.

The technician, usually a man, cuts the scalp at the back of the head from ear to ear with a knife 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 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 the mourners. The skull top makes a slurping sound when lifted from the valuable Dura matter that covers the brain. The top half of the skull is replaced and the scalp and hair pulled back over to reveal the face. Often jaw bones, eyes, inner ears and cartilage are taken making it impossible to display the face at the funeral.

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 remove and wash the major leg veins and the muscle covering called Fascia. They slice through soft, 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 later used as 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 due to their nasty history of transmitting the terminal Creutzfeldt-Jakob prion disease.

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

Regeneration Technologies, Inc of Florida toss bloodied bones and body parts into machines that remove "blood, lipids, marrow, bacteria, fungi and spores" and may even remove HIV, hepatitis B and C.⁵³

Junior medical staff get stuck with removing and cleaning intestines that stink of vomitus and faeces. They say you remember the smell of gastric acid to the day you die.

Intestines are rarely transplanted except in combination with livers, but without great success. Rectums are not transplanted anywhere despite rectal cancer being a major killer in affluent societies. One can imagine the public relations disaster

if a recipient experienced a Graft-Versus-Host reaction where the transplanted organ rejects the recipient.

Funerals More Expensive

Open casket funerals are problematic when much of the donor corpse is missing or damaged. Some bodies better suit a large bucket with a lid than a coffin. Morticians face considerable challenge to create the image of a gently sleeping, fully intact donor when most of the bones have been removed. They shove plastic piping up the cadaver's spinal cavity, legs and arms to mask the lack of bones. They do it cheaper in Australia at the Glebe Institute of Forensic Medicine, also known as the Sydney City Morgue. Former employee Simon McLeod said they used a broom handle on an elderly lady after removing her 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. That corpse would have needed an extreme makeover for an open casket funeral.

The Sydney City Morgue also allowed a plastic surgeon to sneak in and practice nose jobs on corpses. Relatives were not asked for permission. You can imagine their reaction at seeing their newly deceased beloved with a different nose.

Morticians also fill newly created gaps with gel filler, plug the holes, tape and wrap the bodies and put them in a liquid and odor-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 skinned, gutted and boned.

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 cost of funerals for relatives of organ donors. There have been suggestions of compensation to the estate of the deceased though some suggest this is a subterfuge to paying for organs.

Chapter 8

The Nurse's Tale

Transplant coordinators and donation agencies tirelessly promise donor families their loved ones will be treated with dignity and respect. Families are led to believe that 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."⁵⁴

Chapter 9

Types of Donors

"Brain dead" donors: Humans with beating hearts and blood circulation declared dead due to serious brain injury. They're called "heart-beating cadavers" within the medical profession who also refer to them as "dead" when speaking to the general public.

Biologically dead donors: True corpses without heart beat, respiration or brain activity. They are harvested for virtually everything except vital organs. These donors have died from injuries and illness and not from the organ harvesting process.

Living donors

1. **Voluntary:** Humans in good health donating a kidney, bone marrow, blood, section of liver or lung. They're expected to remain alive after donation though a small number die from the procedure. Donors giving bones via amputations and hip replacement surgery are also classed as living donors.
2. **Involuntary:** Also called compelled donors who through a court order are forced to "donate" a kidney to a family member.⁵⁵ In China, prisoners condemned to death also "donate" organs as may do members of Falun Gong.⁵⁶
3. **Coerced:** These donors feel obligated to provide an organ to a relative and don't feel strong enough to say, "no".⁵⁷
4. **Enticed:** Money motivates these donors who usually come from countries with extremely poor people.

Non Heart-Beating Donors (also known as Donation after Cardiac Death)

These are often confused with biologically dead donors because both categories of donors are used when their hearts have stopped beating. The comparison ends there.

1. **Controlled non heart-beating donors:** (See below). These are seriously injured or diseased people with beating hearts who are dependent on mechanical ventilation and, although not certifiable "brain dead", are nevertheless expected to die soon. They're perfused with organ preserving fluids and then life support is removed to allow death to occur (because

cardiac arrest follows). Harvesters wait two to ten minutes and then cut open their bodies. The controversy is about how far gone these donors are in the dying process when the surgery begins. Many or most of them could be resuscitated to their pre-arrest state after such short periods of circulatory arrest. In up to 10% of them, the expected cardiac arrest fails to occur soon after mechanical ventilation is stopped and, somewhat embarrassingly for the harvesters, they are returned to the ward for resumption of therapeutic treatment. This is despite being full of blood thinners and blood vessel dilators, and with raised blood pressure that has damaged their health further.⁵⁸

2. Uncontrolled non-heart-beating donors: These "donation after cardiac death" donors die suddenly from various causes like strokes, heart attacks and car crashes. They are generally unwelcome donors but kidneys harvested within an hour of heart stoppage may be transplanted.⁵⁹

Chapter 10

Donation after Cardiac Death

(Non heart-beating vital organ donation)

One could be forgiven for thinking that Donation after cardiac death is a return to the good old days when organs were removed after the donor died. This was prior to the invention of the "brain death" concept when removing organs from a heart beating donor might have carried a murder charge.

The controversy begins even before life-support is removed and when the patient is still being treated therapeutically in the hope of recovery.⁶⁰

Transplant technicians thin the patient's blood with heparin to reduce blood clotting during harvesting. This may cause bleeding inside the skull of the patient being treated therapeutically by other doctors. Phentolamine is administered to widen blood vessels to protect the organs during harvesting, but may also cause a "precipitous drop in blood pressure and cardiac arrest",⁶¹ which, not coincidentally, is what the harvesting team desires. Perfusion fluids are further added to the blood stream to cleanse the organs of blood and other substances. Warm kidneys inside a warm body lacking circulation may become unusable after an hour, sometimes sooner, depending on how quickly the body and organs are chilled after cardiac arrest. The ethical issue here is that these medical interventions hasten death rather than help the still living patient.

Transplant technicians are reluctant to share secrets about cooling the body before death but here is a brief description.

A saline/gelatine hydrosilate primer containing heparin is pumped into the femoral artery and out of the femoral vein via a refrigeration unit and oxygenator that chills the body to 15C°. ⁶² This extends kidney viability inside the body to hours rather than minutes, which is especially helpful if death has been sudden, relatives can't be found for permission or the transplant team isn't ready with the recipients. Some of this treatment may be performed on living patients.

Ventilation is withdrawn while the prospective donor is still classed as a living person. Surgeons anxiously wait for cardiac arrest, which usually happens within two hours.

Up to 10% refuse to die and annoyingly for the surgery team these chilly patients are wheeled back into intensive care sicker than ever and full of non-therapeutic organ donation drugs. This leaves little doubt that organ donors receive inferior treatment to non-donors. For the other ninety percent that do suffer cardiac arrest death is declared from two to ten minutes after the heart stops and a strange process begins in earnest.

Kidneys from older and less healthy donors may become unusable if left for over fifteen minutes in a body without circulation. This may not leave enough time for excision so circulation may be restarted using cardiopulmonary resuscitation (CPR). It may be done by hand or by using The Thumper™ that compresses the chest 50-100 times a minute creating a rudimentary circulation that feeds the organs with oxygenated blood.

The blood is oxygenated using an extracorporeal membrane, which means the "deceased" patient's blood is streamed through a machine called the "artificial lung". Blood passes from a tube stuck into a large neck vein to the lung machine which adds oxygen then pumps it back into the body through the carotid artery.

The corpse has ceased breathing and is without a heartbeat yet maintains a twilight zone existence. Was two or five-minutes without breath or heartbeat enough to kill the patient's brain? Another quiet dilemma is whether the corpse's heart will begin beating naturally because that is what cardiopulmonary resuscitation is designed to accomplish. And what will the transplant team do if this happens?

Kidneys are further chilled and cleansed after circulation cessation by inserting a double balloon catheter in the aorta that isolates the renal circulation system. Hyperosmolar citrate cooled to 4C° is pumped through the femoral artery in the groin and washes the kidneys of blood to prevent clotting and replaces renal substance to inhibit cellular swelling. The effluent drains from a second catheter placed in the femoral vein.

There aren't standard protocols and some transplant establishments will declare a cardiac arrest patient dead after two minutes to enable them to get useful livers. This contrasts with other hospitals where at this point they are still trying to revive the patient. The key is whether they want the patient "dead" for harvesting or alive. Protocols are based on how much hospitals want to increase organ transplanting rather than objective medical science.

Specialists are reluctant to share professional secrets like whether donors are conscious when life support is removed; whether donor hearts restart beating during cardiopulmonary resuscitation; how long before life support removal are organ preservation drugs administered? Another question arises when a patient doesn't die after life support removal and is then wheeled back into intensive care. How long before this patient is returned for another go and how many times will this be repeated?

What isn't in question is that being this type of organ donor ensures inferior recuperative treatment. And donors aren't even "brain dead" when surgeons begin a process that kills them.⁶³

Chapter 11

Futile transplants and flexible survival statistics

Kidney transplants rarely save lives in the sense that the patient is going to die immediately. They improve a person's life by exchanging an unpleasant and dangerous dialysis and restricted eating regime for a more robust lifestyle that also includes anti-rejection drugs and, sooner or later, organ rejection and the need for another kidney. Hardly life-saving surgery though it is generally considered preferable to dialysis and extends the recipients' lives.

Kidneys are also removed and transplanted for financial reasons. Dialysis costs governments \$50,000 per patient annually. A kidney transplant costs \$70,000 with \$10,000 each year for anti-rejection drugs. With luck, from the accountants' point of view, the kidney recipient will die or the graft survives ten or twenty 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. 30% of Australian adults receiving liver transplants are drug injectors who have ruined their livers with Hepatitis C acquired from dirty needles.⁶⁴

With most illnesses a five-year survival rate after initial recovery is considered a permanent cure. This differs with organ recipients because the patient never fully recovers. 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 eventually defeat 95% of transplanted organs.

Fiona Coote and Professor Mario Deng

Every country performing transplanting has someone like Australia's revered Fiona Coote. In 1984 at the age of fourteen doctors told her she needed heart surgery. She awoke from the anaesthetic with her heart replaced by a transplanted organ. Fiona was angry as doctors and her parents hadn't said 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 in 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.⁶⁵

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

Professor Deng's results showed that those with a high risk of death had a better survival rate than those of a similar illness level left on the waiting list, indicating the transplants 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 said in a British Broadcasting Corporation interview in 2000 that, "More than eighty percent of hearts in Germany are not allocated to those who can be expected to have a survival benefit from cardiac transplantation."⁶⁶

Mario Deng's study conclusion has rocked the heart transplant industry suggesting that waiting lists are crowded with those who could do better with other treatments.

Deng's distressing results corroborated an earlier United Kingdom [transplant audit](#) that indicated the optimism surrounding heart transplanting was not based in fact.⁶⁷

But long before Deng's study and the United Kingdom audit astute observers like David W Evans were observing in 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.⁶⁸ It is notable that the transplant industry has been unable to produce a study disputing Deng's study results. Anyone doubting the above might challenge an organ donation promoter to provide a statistical study that indicates those receiving heart transplants live longer than those of similar need who miss out. You'll be staggered by the obfuscation.

Why Not Restrict Hearts To Those Needing Them Most?

If the transplant industry restricted hearts to the very sickest patients then those who got the hearts would live longer than those of a similar illness level who missed out. However, statistically there would be a lower life expectancy for recipients generally and this would make heart transplanting appear pointless.

Therefore the industry continues to transplant hearts into people who might do better without them.

Previous editions of this monograph contained survival statistics from sources like the United Network for Organ Sharing (UNOS) in the United States. However, I've limited statistics in this Third Edition because of the unreliability of the data.

UNOS provided data to me in 2006 and 2007 that didn't make sense. In 2004 UNOS said there were 2016 heart transplants in the United States then claimed a 79% patient survival rate while also claiming just 68 were left alive. With livers it claimed 6168 transplants performed with a two-year survival rate of 77.9% with just 139 still alive.

Their [online data](#) contains heart patient survival data broken down into age and gender specific rates but not the overall rates. The data appears designed to confuse and made difficult to interpret.

The Australian heart transplant data is equally misleading in that the Australia and New Zealand Cardiothoracic Organ [Transplant Registry](#) won't provide separate one-year patient survival percentages so one can compare each year. For me to present most of the data as factual would be pretense.

Kidney transplant promoters often promote their 90% one-year graft and patient survival data to show the success of vital organ transplant. What they don't say is that some patients are getting their third, fourth and fifth kidneys. These people live by obtaining vital organs from both heart-beating "brain dead" donors and from healthy people labelled "living" donors. Recipients tend to be much older than donors. It isn't a pretty industry with one doctor who promotes transplanting describing it thus: "*Organ donation is fundamentally ugly – removing organs from bodies is distasteful no matter how you paint it...*"⁶⁹

Most of us have heard media stories where the right match of donor bone marrow can save a Leukemia sufferer. It's a relatively benign though painful process for the donor: a needle removes a half litre of marrow from inside the hipbone. The marrow donor is under full anaesthetic and out of hospital in seven days.

But we don't hear how long the patient survived. One rare source says, "The actual one-year survival of the 141 patients was 40.0%"⁷⁰ Leukaemia is often a slow killer and most patients might live longer if they avoid a bone marrow transplant. At best it appears an experimental procedure and not a lifesaver.

Chapter 12

Body Parts and Business

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 frequently 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 another source of donors.

The Hidden Industry

But there is a hidden industry for which statistics aren't publicly presented and to which donation agencies feign ignorance. The reader might test their local organ donation centre on this issue.

There is a huge worldwide market for completely dead donors whose hearts and everything else has stopped. They are really dead. Their vital organs are rarely used due to decomposition and damage during the dying process. Yet these cold bodies still provide raw material for surgical activities ranging from heart valve replacements to cosmetic surgery.

The American dead body processing industry is far more advanced than the Australian but demand for our cosmetic and surgical techniques is on par with the Americans. Our industry is fed with imported body products salvaged from American bodies. Our demand for cadaver products encourages Americans to aggressively harvest their own citizens. Australians are indirectly responsible for this strange American activity.

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 donation 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.⁷¹

Worth More Dead than Alive

This isn't a joke. A single donor body can provide the raw material to generate products selling for US\$220,000 wholesale.⁷² 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 more dead than alive. More than a herd of cattle or fifty-thousand chickens.

Our dead bodies are a market commodity and a factor motivating transplant coordinators to pressure relatives to release their next of kin for harvesting. A hungry market raises prices so the body parts industry aggressively lobbies governments, manipulates public opinion and funds donor promotion registries.⁷³

Shortage of Cadaver Skin for Burns but Plenty for Cosmetic Surgery

When a person is burnt from exploding fuel in a car smash, or a pan of oil slips off the stove onto their leg then the skin is destroyed leaving exposed flesh vulnerable to infection. Cadaver skin placed over the wound protects the body and facilitates the replacement of the patient's own skin.

Harvested skin is also used to cover holes left by tumours and make internal 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 though on average skin from one donor fetches \$3600 when used to treat burns victims.

Twenty thousand cardiac dead donors annually in the United States would provide more than adequate quantities of skin for medical purposes, but there is a continuous shortage because of corruption. Non-profit body donation Foundations receive the bodies for free then pass them on at a token price to cosmetic companies who set up the Foundations in the first instance. The processed skin from one body, worth \$3600 when used for burns victims, is instead transformed into cosmetic surgery products which sell for \$36,000 wholesale. This business practice means that burns victims don't get the cadaver skin. Instead, surgeons strip skin from the burns patients' living relatives who, despite full anaesthetic, say it is the most painful experience they've had.

Thick Penis Treatment

LifeCell Corporation uses donated cadaver skin to produce 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 display such big 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 to fatten lips or reduce wrinkles and laugh lines by puffing up the skin. The benefit of Dermalogen is that the body doesn't break it down so repair jobs are less frequently needed. The drawback with this injected cadaver skin is its permanent nature. Ghastly mistakes are hard to fix as evidenced by a number of freaky-looking TV personalities whose faces look like clown masks.⁷⁴

Alloderm and Dermalogen compete with similar products cultured from the bugs living in the fluid of arthritis sufferers' swollen joints. The "stuff" is injected into the face puffing it up like arthritic fingers thus taking away the wrinkles. The body absorbs the "stuff" and the expensive injections must be repeated every six to twelve months. Similarly, cowhides are made into a collagen and pumped into wrinkly faces. Allergen makes Botox, another wrinkle reducer, from botulinum toxin A, which is related to botulism. It paralyses facial muscles to stop those natural facial movements that cause wrinkles.

Have you ever admired the thighs of scantily clad movie 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 movie stars, which may explain those incredibly firm and tight bodies.

Football and sports heroes don't miss out on the cannibal trade. 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 are used for varicose vein and blood vessel reconstruction and 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.⁷⁵

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 for body pieces so the industry relentlessly pressures governments for increased access to corpses. They'll hire slick advertising people to portray this form of cannibalism in the most heart-warming manner making people feel greedy if they don't give the sometimes still warm bodies of their deceased next of kin to the harvesters.

The human body has 206 separate bones most of which will fetch a reasonable price, but it is the processing and transplanting stage where the biggest profits are made.

Bones are deep-frozen or freeze dried at 92 degrees below zero Fahrenheit (<71C), which ensures a five-year Use-By period. The first stages of bone processing are so simple that some American doctors have taken cadavers home and removed the bones in their garages. Bones are later irradiated to minimise rejection and increase storage times. They're often stored for six-months to allow time to perform disease checks. Living donors via amputations and hip replacement surgery are observed for this period to see they fall ill from certain infectious diseases. If they're still okay after six months the bones are used.

When you consider the diseases that may be transmitted by the natural procreative sexual act then incorporating another person's body part inside oneself permanently is like opening a floodgate to new infection possibilities. Donors may have been unaware they carried the Hepatitis virus; Creutzfeldt-Jakob prions, (similar to Mad Cow Disease); the Epstein-Barr virus that causes glandular fever; HIV-AIDS; cancer; you name it.

Young donors with strong vibrant bones fetch high prices while the porous bones of older women 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

Carpentry shops cut and grind human bones into specially manufactured parts for hospital and dental surgeries. These include bone chips (looking like grated parmesan cheese), screws made from bones, wedges, spears, blocks and a large range of custom made parts used to reconstruct, patch or replace the effects of injuries and illness suffered by living humans. Bones are also made into bone putty.

Osteotech, Inc makes a bone putty costing US\$853 for two teaspoons that is used to patch up bone cracks in living humans.⁷⁶ Larger cracks are mended using a chip and putty blend. Crushed bones help fuse together ceramic and bone during hip replacement surgery.

Regeneration Technologies, Inc (RTI) in Florida also manufactures a bone putty called Regenafil. It's also made from human bones mixed with a gelatin-carrier base sourced from pigs. And they do a roaring business processing up to 4000 bodies a year using similar cutting machines that Boeing and Lockheed Martin use to cut aluminum.⁷⁷ RTI doesn't offer factory tours for school classes.

Demineralised human bone is ground into "dental dust" and used to improve healing after tooth extractions, spinal fusions and minor surgery. Like bone putty this "dust" is made by removing the 70% mineral content from bone leaving the 12 morphogenic collagen and non-collagenous proteins.

Dentists spray this "dust" onto healthy exposed bone after grinding out rotting teeth and jawbone. This speeds up healing.

It also helps fuse bones together when transplanting bone material from a corpse to a living patient. 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 the transferal of HIV-AIDS, a problem reportedly 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 hadn't been developed.

Hospital staff usually avoid the skin and bone harvesting that is done by a less skilled team from a euphemistically entitled Tissue Bank. Compared to vital organ harvesting their work resembles a butchering job and is usually performed at the Tissue Bank.

American Tissue Banks operate like the non-profit Musculoskeletal Transplant Foundation. It's 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. The Foundation obtains bodies free of charge then transfers them to Osteotech for tiny prices that then process each body into hundreds of thousands of dollars worth of products. The Musculoskeletal Transplant Foundation produces a catalogue listing 650 body parts products for sale. They aren't alone because virtually every American body procuring benevolent foundation is a secret agent for a private company.⁷⁸

Australians use more subterfuge and hide their body parts businesses within government science and educational institutions. The Donor Tissue Bank of Victoria discreetly operates as a business within Monash University and the New South Wales Bone Bank hides out at St George Hospital in Kogarah. An Australian characteristic is using the guise of medical post-mortems to remove body parts unlike the American model where relatives are directly approached to donate the body.

Australian harvesting for non-vital body components is bureaucratically cumbersome. There are strict disease controls that slow down the procurement of body parts and these are used by dissidents within the medical profession and government.

The South Australian Tissue Bank operates under cover of the Institute of Medical and Veterinary Science in Adelaide. It's amongst a cluster of buildings that includes the Royal Adelaide Hospital. One employee told me that harvesting was limited because bureaucrat impediments slow down the bodies passing through each level of hospital bureaucracy on their way to the harvest room. A single delay may push the body beyond the 24-hour harvest window after death. Disease fears are another factor and one freezer contains bones rejected due to respiratory flora contamination: someone breathed on them. "In the fridge behind the wall," my informant advised me.

These impediments insured that just four bodies were harvested for bones in the first eight months of 2006 and just one in 2005.⁷⁹ This is from a population of 1.5 million people with almost half registered as organ donors and from which two dozen "brain dead" donors are harvested annually. Consequently, there are "more requests [for bones] than donations" so bones are obtained via amputations and hip replacement surgery.

The New South Wales State government in Australia had this same problem so they adopted the American model. Special legislation allows non-doctors from the government-owned New South Wales Bone Bank to harvest bones from bodies supplied by the Glebe Institute of Forensic Medicine, also known as the Sydney City Morgue.

The Bone Bank sends these bones in cooler boxes to the commercial outfit, Australian BioTechnologies, which operates out of the northern Sydney suburb of Frenchs Forest. They grind these bones into shapes for transplanting and process the shavings into bone putty then sell these products back to the New South Wales Bone Bank. This bypasses the medical establishment, which can no longer obstruct "progress".

Our predicament is that we have a medical industry on which over 500 surgical procedures depend on human body products. National governments fund this

medical industry and while this continues our wellbeing will remain dependent on a form of cannibalism that we euphemistically call “body parts recycling” or the “gift of life”. It isn't pretty and some say it isn't a particularly efficient system of maintaining health.

Aaron Vowles was twelve-years old in 1994 when he and his brother were emptying a compressed gas cylinder one evening in their Adelaide backyard. A gentle wind pushed the gas cloud into the pilot light of an outdoor water heater. The fireball melted Aaron's nylon tracksuit burning sixty-four percent of his skin which turned black and fell off. Doctors put Aaron into an induced coma but he still suffered a cardiac arrest.⁸⁰

Aaron needed cadaver skin to cover his burnt body and protect him against infection until his own body rebuilt skin cover. There wasn't any skin available despite South Australia's aggressive harvesting program of "brain-dead" organ donors.

Aaron's brother, Damon, and their father entered hospital to have skin stripped from their bodies. Damon told me it was the most painful experience he'd ever had and all the anaesthetic and other painkillers didn't work.⁸¹

Chapter 13

Coercion, Live Donation and Slippery Ethics

Transplant agencies relentlessly feed the media stories like that of a tragically killed teenage boy saving the lives of four or maybe five people by donating his organs. The truth is often different.

Transplant coordinators 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 sleeping in a hospital bed. Coordinators or intensive care staff face the difficult task of convincing these parents to allow surgeons to cut and saw into this warm body with its beating heart then 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.

But even this coercion won't address the issue of "brain dead" donor numbers remaining stagnant while demand for kidneys soars. One attempted remedy is by obtaining kidneys from "living donors".

"Remember that is your decision...It's OK to say NO!" This is the advice given to prospective kidney donors in "*Kidney donation by live donors*", a publication from the Australian state government of New South Wales. It raises the question whether live donors offer one of their kidneys or do the patients and transplant coordinators put the hard word on friends and relatives. If donors volunteered then why would a government agency tell them it was okay to say no? I asked this of Marion Downey of the New South Wales Department of Health, but she refused to answer.

This emerging attitude of governments encouraging those on dialysis to pressure relatives to give up a kidney is further exemplified by Sir Peter Bell, Professor of Surgery at the University of Leicester in the United Kingdom.

"I think you could do a lot to encourage live donation from relatives. I think it is wrong to be talking about buying organs from the third world when they have relatives who they could go to, all of whom have not offered a kidney. How can that be right? As long as it is done with proper informed consent, it is a thing to think about."⁸²

Pressure is also applied to renal failure patients to join the kidney waiting list. Nicholas Tonti-Filippini, a former health care ethicist in Australia, reports:

“...as a hemodialysis patient I have often sat with other patients to whom the alternative of a cadaveric kidney transplant was being put most forcefully, on both economic and personal health grounds, and seen the patients’ disquiet at the prospect, and their unanswered questions about anything to do with the source of the organs.”⁸³

A proclaimed ethical concern of most hospitals, currently, is that before a kidney is removed from the body of a living donor there must not be any suspicion that payment is involved. Some countries disallow transfers of kidneys from low-income donors to wealthy recipients to safeguard against the possibility of payment.

Nick Ross reportedly gave one of his kidneys to his billionaire employer and Australia's richest man, Kerry Packer, in 2000. They were said to be lifelong friends and Nick received a one-million dollars annual salary for being Packer's helicopter pilot.

The surgery was approved by the ethics committee of the Royal Prince Alfred Hospital in Sydney and performed there successfully. Packer subsequently donated \$10 million to the hospital, part of which was used to refurbish the newly named Nick Ross Clinic. Packer died in 2005, aged 68.

I asked the Royal Prince Alfred Hospital for a copy of their ethics guidelines. These guidelines typically require that living donors are not being coerced or paid, they're informed of the risks to themselves and the fact that the recipient can still survive without a kidney through dialysis.

The hospital failed to provide me with the guidelines and I followed the request up the chain of command to the Health Minister, Morris Iemma, now Premier of New South Wales. His only response was through Marion Downey who posted the above-mentioned donor guide: "*Kidney Donation by Live Donors*".⁸⁴ It said that living organ donors must be: psychologically stable, freely willing to donate, free from any coercion, medically and psycho-socially suitable, fully informed of the risks and benefits, fully informed of the effectiveness of current dialysis treatment available to the recipient"

Significantly, it didn't remind prospective donors that it is illegal to sell one's organs nor did it prohibit inducements either to the donor or to the hospital. These are the issues I wanted to discuss regarding the Packer transplant.

This concept of the rich purchasing body parts from the poor is creeping up on us by stealth and has a logical basis according to Robert Veatch. Feel the ice in your veins as you consider the logic from this leading American intellectual.

"If it is immoral to make an offer to buy organs from someone who is desperate because those making the offer refuse to make available the alternative solutions, [adequate access to food, housing and medicine, etc], it must be even more immoral to continue under these circumstances to withhold the right of the desperate to market the one valuable commodity they possess. If we are a society that deliberately and systematically turns its

back on the poor, we must confess our indifference to the poor and lift the prohibition on the one means they have to address their problems themselves.

It is thus with shame and some bitterness that I propose that the time has come to lift the ban on marketing organs...⁸⁵

However, there is a downside to being a living donor. From Israel:

"It must be noted that removing a kidney, even from a healthy person, presents certain dangers. This is an organ that does not restore itself, unlike blood or sperm. The donor, therefore, is left with a defect."⁸⁶

And from David Evans in the United Kingdom:

"The short-term risks include life-threatening haemorrhage, pulmonary embolism, pneumothorax, infection, transfusion-transmitted hepatitis and AIDS. In the longer term, there is increased risk of hypertension and renal failure. The long-term psychological effects upon the donor are not known."⁸⁷

And from Steve Chadban in Australia:

"At an individual level, the risks associated with donor nephrectomy are borne largely by the donor. These include the risks of complications arising from invasive investigations (particularly angiography), the risks of surgical complications including death, and the long-term impact on risk of end-stage kidney disease and death..."⁸⁸

Chapter 14

Deception by Organ Donor Agencies

“Until relatively recently (1992), as an ethicist, I was myself misled in this respect, having had brain death explained to me and seen it explained to donor families many times as the brain event equivalent of having been guillotined. Having now studied the medical literature I know that to be false, and more than that, it was known to be false as early as 1977 following the multi-center study funded by the National Institutes of Neurological Disease and Stroke.”

Nicholas, Tonti-Filippini.⁸⁹

The least reliable sources for accurate transplant information are government organ donation agencies. They won't tell the whole truth. They lack faith that people with a balanced understanding will sign up as organ donors. They prefer the used car salesman tactics of trickery and deceit to entice donor registration. They suspect that informed citizens knowing both the positive and negative aspects would avoid organ donation like the plague. 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 and trailers outside shopping centres throughout the country. They pretend to offer free blood pressure tests and kidney health advice.

I entered their caravan trailer in Rundle Mall, Adelaide, and before I'd uttered a word was hit with, "Do you want to be an organ donor". I said, uh, no. The atmosphere turned heavy and the three staff clenched their mouths and stared at pieces of paper. I mentioned the blood pressure test which one woman performed angrily then, without indicating the result, returned to her piece of paper. Asked about the result she muttered, "okay", and "more exercise". Their blood pressure tests and kidney health advice were a subterfuge to obtain donors.

Their promotional slogan *Give & Let Live* should be called "Sacrifice and Extend" because kidney transplants rarely save lives. They exchange dialysis for a transplant. Dialysis means having one's blood filtered through a machine three times a week. It's an unpleasant, unhealthy experience that means constant chemical and mineral imbalances. Patients won't die in the immediate future from kidney failure as long as they get dialysis. It also means a shorter life span though some prefer it to a kidney transplant though neither option is pleasant.

Getting a kidney transplant means a more robust lifestyle and is generally preferred to dialysis though its drawback is immunosuppression illnesses.

Kidney failure devastates people's lives especially Aboriginal people in the Australian outback. Noelene Lester told me at Port Augusta in 2005 that kidney donation was like a non-profit cottage industry and described her various relatives according to kidney status: recipient, living donor, "brain dead" donor, on dialysis and waiting for kidney, dead from renal failure.

Further north Aboriginal people have ceded land rights⁹⁰ to the town of Katherine in exchange for a kidney dialysis machine.⁹¹

Sleazy, Deceptive 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 the heart continues to beat and the body remains soft and warm. The Australian Kidney Foundation promotion material doesn't explain the amount of body parts that may be removed. The phrase *"Any part of my body"* isn't limited to 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 before and not after potential donors understand what they are getting into.

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 showed 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 for 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 just 273 waiting for a "lifesaving" transplant, 87 of which were waiting for livers despite many having ruined their livers through alcoholism and 30% from Hepatitis C via dirty needles.⁹² 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 and

synthetic insulin. Graft survival rates average less than five years at which time the recipient may be demanding yet another pancreas.

This leaves 120 patients waiting for hearts and lungs of which 10% are on their second and third hearts. In any case, over half the heart recipients⁹³ will live longer if they don't get a transplant, as explained in Mario Deng's study.⁹⁴ This leaves very people on the Australian transplant list whose lives will actually be saved by a transplant. Then we can ask: for how long and of what quality?

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

The Japanese government paid for the surgery allowing the Princess Alexandra Hospital in Brisbane to maintain and improve its transplanting skills. It also made a small profit from the surgery, which also alleviates the government footing the bill, which would be the case if the livers were transplanted into Australians.

Wendy Edmond, then 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 denied liver transplants because it was more profitable to sell them to the Japanese.⁹⁵

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. It wasn't like pulling them from a raging river and then they went on to have long, healthy lives.

The leaflet avoids informing the donor at what point their bodies will be harvested 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, that 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. The condition they refer to as, "brain function stops forever", is usually terminal within a few days though some parts are still alive on harvest day. 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 is hoping to do with 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.

And to whom were the promoters aiming their leaflet? The large, colourful picture on its front showed young people singing with upraised hands and closed eyes similar to that seen at Christian Revival meetings.

Donor Card Aimed At Children

The attached donor card on the above-mentioned leaflet distributed by the South Australian Organ Donation Agency was also 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. The harvest promoters target children away from their parents. Promoters cover themselves saying children must have parents or next of kin consent and this is merely a symbolic gesture of a child. They're right because hospital protocol allows parents or next of kin to veto or agree to donation regardless of a child's intent.

But 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 a pool of potential child organ donors as children have a low death rate and the transplant industry wants every kid it can get.

The Australian Transplant Awareness Association published the leaflet and donor card, but who are they? Karen Herbertt, then Executive Director of the South Australian Organ Donation Agency that distributed their material, told me in 2002 that she couldn't remember. However, at least Karen would speak publicly. The new manager, Ms Kathy Hee, won't submit to an interview or even answer questions by email and barricades herself behind locked office doors.

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 within a 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? Hardly, unless 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

The Australian Consumers Association publishes Choice Magazine that analyses the quality of products and services. They test items like washing machines for noise, water and power use, operating costs, purchase price, reliability and quality of wash.

The August 2000 Choice ran an organ donation article which featured deaths on the waiting list, happy transplant stories, how to register for donation and listed addresses of donation agencies. Choice used euphemistic language describing skin, bone, ligaments, tendons and fascia 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 criticism by avoiding the negative aspects of transplanting. 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 American statistics.

Choice staff wrote the article to promote transplanting rather describe the pros and cons of organ donation.

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, 2001⁹⁶ 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 will be 5.5%, according to American statistics from the United Network for Organ Sharing (UNOS). This is a higher death rate than if he misses out on the transplant 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 may want another one requiring further surgery. Nor will he ever be free of illnesses accompanying the suppression of his immune system.

Time magazine 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 eyesight or for kidney transplants.

Chapter 15

Australian Transplant Legislation

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

This includes even those who haven't signed donor cards or registered an objection to donation: 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 dead" 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 safe 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. These include blood thinners, increased fluid drip and blood vessel dilators, all of which may increase brain damage while the patient is theoretically still receiving therapeutic treatment.

"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 the harvesting of their children than vice versa.

Tightening the Screws

Australian State and Territory Health Ministers changed the donor rules in 2005. Next of kin objections to organ donation would be ignored unless there were "sincere objections". This cavalier approach has always been legally available to hospitals through the legislation but hasn't been enacted for political reasons.

I asked the *South Australian Organ Donor Agency* to clarify what constitutes "sincere objection" but they wouldn't reply despite my putting the request through John Hill, the Minister for Health. The peak transplant body, *Australians Donate* did reply but declined to define what constitutes "sincere objection" against harvesting one's next of kin. Nor would they say who precisely decides whether next of kin objections are sincere and what are their qualifications to make this decision.

Stephen Bendle of *Australians Donate* did say the decision was made by intensive care staff, but wouldn't give examples of "sincerely held objections" and added that he didn't think there was any appeals process. He also stated that, "*In every case in Australia, the staff involved in the end of life treatment of a patient are never involved in the issues of organ or tissue transplantation.*"⁹⁷

This new rule of ignoring the wishes of next of kin applies only to those registering with the Australian Organ Donor Register from 2006. New donors are registering their *consent* for harvesting while previously prospective organ donors were merely signing *intent*.⁹⁸ Donation agency spin doctors claim that ignoring next of kin wishes increases the opportunity for people to donate organs. Potential donors signing the new forms are locking themselves into tighter contracts that give more power to the harvesters and less to their relatives. The new contract also means harvesting can proceed without even informing relatives until after the event.

Yet residual power still resides with determined next of kin. The worst nightmare of transplant promoters is angry, informed relatives 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 that person's body parts. This safeguard protects patients against a harvester wrongly diagnosing "brain death" simply to grab a patient's organs.

Dr Juro Wada was accused of this in Japan and charged with double murder: once for harvesting the patient's heart before letting a second doctor declare "brain death" and, secondly, for killing the recipient who got a heart he didn't need then died.

Some doctors have an established reluctance to declare "brain death", but transplant teams get around this little problem.

Getting Around "The Problem"

Dr David Hill, the English anaesthetist mentioned elsewhere in this monograph, says the United Kingdom pattern is that doctors reluctant to make quick "brain death" diagnoses 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."⁹⁹

Another Implication for Intending Donors

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 few of us give 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 because you'd agreed to organ donation then you wouldn't have objected to the hospital or medical school using your completely dead body for teaching purposes. 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 cosmetic surgery practice 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 from 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 16

Avoiding Harvest Time

“When members of the family later investigate and find out, for instance, sometimes for the first time, that organs are taken while the heart still beats, or that the practice is to administer a general anesthetic to donors for the harvesting operation (which the relatives often interpret as implying the need to suppress capacity to feel pain indicating continued brain function), they may be extremely distressed and feel exploited.”¹⁰⁰

Nicholas Tonti-Filippini

Harvesters 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 dare not risk nasty reactions from next of kin. But medical technology requires increasing numbers of body parts and the industry players have become increasingly desperate to harvest and transplant more organs. Their representatives, such as Professor Geoffrey Dahlenburg, formerly of the South Australia Organ Donation Agency, once said that a "soft no" by relatives wasn't good enough. There had to be an undefined "strong objection" after some discussion between shocked relatives and desperate transplant coordinators in the hospital waiting room or wherever. Professor Dahlenburg said this back in 1997 and since then the attitude has become increasingly dismissive to the viewpoints of next of kin, especially in Australia and the United Kingdom.

Delivering the Hard Word

The transplant coordinator will sidle up to the relatives in the waiting room and begin the sales pitch by expressing sympathy and hinting that good may come from 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 return later with a continuing stream of ideas reinforcing the 'good from bad' theme, getting closer and closer to the punch line. 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. Their ploy is to undermine relatives' confidence in their legal or moral status, and position the coordinator as a benevolent human. It's usually bluff even if the coordinator has the strongest legal position.

Transplant Coordinators Position Themselves Between Patient and Relatives

Transplant coordinating staff and especially intensive care staff become the communicator of the prospective donor's condition. Relatives depend on their messages and may feel obligated 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.

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 object to it. This will give them a legal standpoint that the patient would not have objected to donating his or her organs and again, that seeking family approval is kindness on their part and not a 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 yet it is still easy to become hypnotised.

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 "hopeless cases" and using them as spare parts.

Hospital Staff Mistrust Transplant Consultants

The position of Transplant Coordinator was invented in the United States after industry promoters discovered Intensive Care Unit staff were reluctant to seek harvest consent. 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 transplant teams.

Australia still uses intensive care staff, predominantly, to seek harvest consent though this will become less necessary as organ donors who signed 2006 registration contracts come into affect and for which next of kin can no longer veto organ removal.

Repelling Transplant Coordinators

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 especially 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 coordinators back off. A secondary defensive action is to keep moving about. One should move about one's body and limbs while seated or walk about the building to avoid the hypnotic stare of the 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 logical argument.

Protecting the Patient

Head injury patients may increase their recovery chances if their relatives insist, with witnesses present, that neither the apnoea test nor any treatment designed to preserve organs for harvest be applied. Stating the patient won't be a donor and had recently expressed distaste for donation will reduce interest from the harvest team. You might also suggest that hypothermia and barbiturate treatment be used to protect the injured brain.

You can also insist on visiting the patient in privacy without medical observation. You can insist on observing the apnoea procedure. You may also insist it not be performed. Reflex testing 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 also protect our dying next of kin and, sadly, in some situations, it is from our own species.

Who Owns A Dead Body?

A patient declared "brain dead" with a beating heart hasn't any legal rights. This means many of the patient's directives on treating their injured body are not legally binding. Power of Attorney or Advance Medical Directives allow you determine medical treatment prior to death and when you may be unconscious. The contrived "brain death" criteria may erase these orders because you're legally dead and Advance Medical Directives generally cover a living person. The fact that part of your brain is alive and your body quite alive make no difference to the harvest crowd.

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 at the mercy of staff who may want to harvest parts while the patient is still warm, pliable and with normal blood circulation mediated by the brain.

More sinister is the concept that our bodies are owned by the species as a whole and not by us as individuals, an apparently benevolent concept until one investigates the motives for promoting it. The organ donation industry want us to think we own our bodies until our health deteriorates then, like a Microsoft Application — we have sudden become mere licensees. This is the mentality we are dealing with.

Protecting Your Body

The legal key to protecting yourself from harvesting is by ensuring people know you are an organ keeper. You might tell your legal advocates and donation agencies that you require an intact body for burial or cremation. Writing "organ keeper" or "organ retainer" on your documents helps. I put "organ keeper, no harvesting, thanks" on the back of my car. This angers donation agencies but they've brought in on themselves by making it very difficult to register a "no harvesting" decision on government donation data bases.

The Australian Organ Donor Register is the computer database available nationally to medical and transplant promoters. It is designed to allow medical staff to identify prospective donors immediately on arrival at a hospital. Organ keepers can also register their choice on this Register. This is an encouraging development that should be followed around the world. It isn't failsafe though because one cannot be fully assured that the register won't be changed before "harvest day". The problem is that the registration form is essentially for donors. One must complete 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 keeper. This leaves one vulnerable to a harvest agent who change that single box to make one a registered harvest candidate. It would more likely, though, be changed through error by a bureaucrat processing dozens of organ donation contracts per shift and not noticing the exception.

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

The Australian Organ Donor Register's 2006 paper application form has changed with the inclusion of a checklist of organs that can be donated. This replaces two tiny lines on the old form where the donor could list parts he or she did not want to donate, and where one could easily miss something out. The new form is better though still uses euphemisms like "eye tissue" for eyes and "skin tissue" for skin. The only indirect mention that the donor's heart will be beating during the sawing and cutting process is the line: *"In some cases organ donation may be possible after a person's heart has stopped beating, but this is rare."* They don't use clear language because people might abandon donation in droves.

The most deceptive aspect of this new application form is not telling prospective donors that relatives can no longer veto donation. This means many older people might update their details not realising that their partner or next of kin will no longer play a controlling or protecting role in their dying and donation process. Next of kin have been demoted to "...an important part..."

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

But what adds insult to injury is the first section of the form. On the previous donation consent form the person signs under the words *"I wish to record my donor status on the Australian Organ Donor Register."* On the new form this has been replaced with, *"Please register me on the Australian Organ Donor Register."* A command by the donor has been replaced with a request. This represents a major power shift where the generous organ donor is now treated as a supplicant.

Organ Retainer and Organ Keeping Cards

You may find further protection in the coercive political environment of organ transplanting 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. We hope.

Australian and World Organ Retainer Cards

These simple cards are available from The Nasty Side of Organ Transplanting¹⁰¹.

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 activity thus three choices was the most intrusive legislation their transplant industry could get from the government. It is important to circle your choice with a scratch and then ink over the scratch. You might scratch out other choices to prevent 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.¹⁰²

Organ Keeper Cards™¹⁰³

Duane Horton is an engineer and entrepreneur from Rhode Island, USA. He advocates paying 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 one of the world's leading donor rights activists.

Duane publishes his trade marked OrganKeeper card that signifies the holder wants to retain organs upon "brain death" and real death. There are six choices each explaining 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. You can print the cards from his website.¹⁰⁴

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 on electronic registers cede control of their 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 when you're unconscious. You should have a note on your person naming your representative.

Tattoos are a permanent form of registering your organkeeper intentions. A harvest surgeon might be reluctant to slit up the torso of someone with Organ Keeper tattooed in big letters across his or her body. It could also be a problem if you 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 agents. Dated organ keeper cards can also counteract your having signed a donor card or an

electronic register then forgotten and later changed one's mind. Organ 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 17

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 remove organs from registered donors. After all, it isn't legally required.

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 understand the processes except the advertised idea of dead bodies being used to save beautiful peoples' lives.

But the reality is slowly sinking in. 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 dies.

To avoid negative reaction to transplant legislation the astute government orders its bureaucracies to gradually promote and introduce organ donation 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"¹⁰⁵, who hired models, professional actors and a stand-up comedian to promote "awareness". These paid actors pretended they loved being donors despite the fact that real donors are never able to return to say how they felt about the harvest experience. Media kits include photographs and video clips of smiling children with organ transplants and "donor" relatives saying how wonderful they feel about having donating the heart-beating bodies of their "dead" children. The Australian Government won't say if those who were paid to have their images appear on organ donation campaigns have registered as organ donors or not.¹⁰⁶

These promotion campaigns are run by government agencies with Pharmaceutical Corporation funding and are replacing medical staff with public relations experts to promote transplanting.

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. These small groups may produce 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. The aim is to lull the public into feeling there is a huge undercurrent of positive sentiment towards transplant medicine so it must be good. But it's just a government 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 any law. Volunteer behaviour becomes compulsory behaviour where dissidents or resisters are branded as deviants or extremists.

But until this societal consensus is formed transplant coordinators will display consideration despite the law allowing hospitals to remove organs from most donor card signers without seeking next of kin consent. If this consensus is formed then even those wishing to die intact may find it rather difficult. This is because most countries don't operate donor registers that include the option of registering one's objection to organ donation. It pays to carry an organ keeper card and have an advocate to represent your interests if you suffer brain injury.

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 bodies.

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. Yet we can't kill the sick or let them die when the life-saving 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 has increased demand for fresh organs.

On the supply side of the equation, raw materials aren't keeping up with demand. Car smashes are producing less brain-injured bodies while the treatment of brain injuries, including strokes, is improving. Young men, in particular, have become less enthusiastic to beat each other around the head thus denying the transplanters 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 harvest coordinators. Supply is not rising to meet demand so governments are pushing harder and harder to increase or simply maintain supplies of vital organs.

More Pressure on Relatives

So it shouldn't be any surprise when the Australian and United Kingdom governments begin denying veto harvesting rights to next of kin. Relatives will be required to display "sincere objections", a definition of which these governments keep secret. Nor will they say who determines sincerity, how that person is qualified or whether an appeal process exists against a harvest decision.

But governments around the world face a problem. If transplant coordinators apply what could be seen as draconian laws then relatives will question the legislation and may form anti-donation organisations. Governments walk a tightrope between increasing supply and avoiding a backlash.

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 everyone's body unless each person registers 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."¹⁰⁷

There are two reasons why "opt-out" isn't universally adopted. Many people 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 of citizens registering as organ keepers who normally wouldn't consider it. Brazil chose presumed consent but it backfired when people rushed to register the preference to keep their organs. One Brazilian summed up his 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."¹⁰⁸

Spain and United States have the highest per capita rates of organ donation. Spain has presumed consent though in practice they still seek consent from relatives. Most states in the United States have an opt-in system but consent is not always sought from relatives.¹⁰⁹ Other opt-in countries are New Zealand, Australia, Canada, the United Kingdom, Germany, Japan, Ireland and the Netherlands though consent is not always sought from next of kin of registered donors.

Organ Donation around the World

Japan has some of 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 "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 the heart has stopped. This differs from most countries where kidneys from cardiac dead donors aren't used though there is a trend to harvesting kidneys from these sources.

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 they weren't taking any chances. It was insurance in case the father later became disillusioned.

Austria, Denmark, Poland, Latvia and part of Switzerland are the fastest countries to remove organs without consent or notice. International travellers with dual citizenship visiting these countries should carry organ keeper cards and advise relatives of their "no harvesting" decisions. It should be noted that countries often apply their laws to international tourists, but generally any organ keeper indication will protect that person.

"Softly, softly" Increases Harvesting

European countries that applied presumed consent suffered the Brazilian organ retainer reaction. They found their harvest rates lower than Spain and the United States that seek next of kin consent.

However, both "opt-in" or "opt-out" transplant programs are geared to increase supply through persuasion and compulsion rather than increased understanding. Harvest strategists know that informed citizens will resist registering as donors and refuse consent for harvesting of their next of kin. Resistance has already begun.

Anecdotal evidence from the industry indicates that refusal rates from relatives have been 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*, a "refusal rate" by families of potential donors of 82% in 1999 in the Australian State of New South Wales – up from 56% in 1995.¹¹⁰

Bruce Lindsay of Australians Donate reported a refusal rate of "nearly 50%..." This was in a letter from Bruce thanking me for my interest in becoming an organ donor. Actually, I had written them asking how to register as an organ keeper.

An extreme approach to bypass citizen resistance to *Give and Let Live* is to target unpopular groups. The Chinese government makes prisoners "brain dead" by shooting them on demand to satisfy local and foreign "organ tourists". It proved so popular the government has allegedly expanded the scheme to include Falun Gong practitioners. But for other Chinese the organ donor concept has proved unpopular. They don't understand why anyone would voluntarily become a donor. Organ donation is for losers in China.

The United Kingdom government has dealt with the same problem with typical British subtlety. They lowered the requirement for "brain death" declaration by assuming that serious brain-stem failure is identical "brain death". To avoid pesky debates over the medical definition of "brain death" these deviously clever British have re-labelled it "Certified Dead". This means you're dead when the doctor says you're dead: end of debate. The government introduced this change when both lay-people and medical experts claimed the "brain death" condition merely predicted death.

Governments have responded to resistance by saying those who doubt the "brain death" concept and resist donation are uneducated and superstitious.

However, Nicholas Tonti-Filippini, himself a victim of renal failure, knocked this one on the head by saying, "Anecdotally, the wealthier, more educated communities in Spain have a relatively low compliance rate with organ donation"¹¹¹

Chapter 18

Terminology and Gender Donor Rates

Reduced Status of Intending Donors

The body parts industry developed a new language to disguise the fact they were cutting up patients still showing signs of life. They solved the problem by reducing the donor patients' status to heart-beating cadaver much sooner than for non-donor patients.

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's called a corpse. When the stiffness of rigor mortis sets in the status is reduced to cadaver, something absolutely dead.

The status of a dying organ donor descends much quicker. Despite the patient making a magnificent final gesture, transplant coordinators label him or her 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 some brain activity and function.

An organ retainer in the same condition would still be treated as alive: washed, fed and talked to by nurses and doctors. But surgical staff need to delude themselves, for their own psychological well being, that the donor patient is stone cold dead.

Refusal to Differentiate Between Cardiac Dead and "Brain Dead" Donors

Donor Agencies sensed the danger of people differentiating between "cardiac dead" and "brain dead" donors. People would see that one appears less dead than the other. So they adopted the "Dead Donor" term that describes either a completely dead patient or a "brain dead" human. The term, "Living Donor", was restricted to those walking around and expected to remain alive after the donation. These definitions were formulated to avoid the obvious fact that there is little similarity between being a "brain dead" person and a cold corpse.

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 refers to "staying in bed and drinking plenty of fluid", but that the patient is dead because the doctor says so. "Doctor's Orders" determine if the donor retains human rights or is treated as "the cadaver".

The word "homograft" is used in Australia to define a transplanted body part while Americans prefer the word "allograft". Homo means homosexual in the United States and they don't want people to think the body parts come from homosexuals. They might be derived from that source but not specifically.

Ethnic Origin of Donors in Australia

192 of 204 "brain dead" donors in Australia in 2005 were Caucasoid and of these just two were Greek and Italian.¹¹² "Brain dead" organ donation is a "white folk" thing.

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%

Like many trades and professions transplant promoters develop euphemisms to mask the graphic aspects of their business from the public. Below is a small sample.

Transplant Industry Description	General Public Language Use
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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) acceptance of transplant industry beliefs.
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"	Pressure relatives to allow harvesting.
We need to know.....	We demand to know.
"Sincerely held belief" against transplanting.	The industry won't define this term.
"organ rejection"	The immune system is killing the transplanted organ.
"SNOK"	Senior Next of Kin

Chapter 19

Getting a Transplant

Many transplant hopefuls won't admit it but they feel a peculiar tenseness on public holidays like Easter and Christmas. The screams of ambulance sirens on these days send bursts of hopeful energy through their sick bodies. Their success depends on a young man, usually a man, suffering catastrophic brain injury that leaves his 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 requires a failing vital organ but must retain enough strength to survive the waiting list, surgery and immunosuppression illnesses. For example, a patient may need a heart transplant but if he or she also has a bad liver this throws doubts on getting either. This is because the main anti-rejection drug, Cyclosporin, damages the liver and to withstand it a heart recipient needs initially a strong liver.

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. Fat is another exclusion factor as the drugs cause huge weight gains 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 Shouldn't Have Psychotic or Depressive Tendencies

Mental stability is crucial because organ recipients often become psychotic, bipolar or depressive after a transplant. The shock of surgery, the drugs, chronic wound pain and faulty transplant organs are enough to send patients insane anyway so a predisposition to mental illness may exclude one 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 know the truth. 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 chronically 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 recipients need to maintain intake of anti-rejection drugs while observing them create new diseases like cancer tumours, diabetes and organ failures. Any disobedience to doctors' orders may allow the immune system to begin destroying the transplanted organ long before the patient senses it. Mental and physical stamina are required to undergo unpleasant 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 waiting or be taken off because other illnesses develop that lessen the ability to survive surgery. However, all is not doom or gloom. Some heart patients leave the waiting list when their health recovers or they undertake less drastic and more successful treatments.¹¹³

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 previously transplanted material and pregnancies. When a patient is seeking a second organ the first transplant 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 donor. Therefore, the second transplant must come from a donor with a different Human Leukocyte Antigen (HLA) type to minimize the savagery of the immune system reaction.

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. This can prove a severe impediment to a successful

transplant if the hospital is unable to track down details of previous blood transfusions especially if the patient has received dozens of them.

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

A woman's immune system tries to kill her unborn child because it experiences the embryo as a malignant tumor. The embryo (or foetus) disables this attack and the mother's body accepts the child as part of herself, but not before her immune system permanently records the baby's HLA and blood type as an enemy to be attacked in the future. Transplant technicians therefore need to identify the blood and HLA types of all previous pregnancies of female organ recipients.

This shows the importance of identifying previously transplanted material, pregnancies and blood transfusions. Transplanting body material familiar to the recipient's immune system could trigger an instant and deadly antibody attack of a ferocity usually reserved for xeno or animal tissue transplants.

The next matching process is blood compatibility. Transplanting may require huge amounts of transfused blood. Those lucky enough to have AB blood can accept all blood groups. A person with A blood can receive from A and O blood groups only. A person with B blood can receive from B and O donors while someone with O blood can get blood from an O donor only. 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.

Your Waiting Ticket

Doctors assign a Percent Reactive Antibody number and those with a lower reaction to other humans' body materials will better accept a wider range of donated material. These people may jump the queue though many other factors come into play.

Moving up the Waiting List

Younger patients get priority because they're more able to survive surgery. They'll also live longer if their body accepts the organ. Why sew scarce organs into some old dear who is approaching death, anyway. This is the cruel truth.

Being Close To the Donor's Hospital Is an Advantage

When three patients have equal seniority the one closest to the organ donor's hospital will win, as distance between donor and recipient is crucial. Chilled hearts last about six hours out of the body so even a three-hour flight between cities, plus courier times to and from the

airport, may be too long. Heart transplant failure rates increase 6% for every hour a cold and paralysed heart sits in the picnic container. A patient in the same hospital as the dying donor has an almost insurmountable lead over similarly matched people in other states.

Avoid Debtor Hospitals

A debtor hospital has received more organs than it has given and must repay the debt. If your hospital or state has been sending its organs interstate then eventually the reverse comes into play. This means that if you and a patient in a debtor hospital have equal priority then you win, and vice versa.

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

Suddenly Deteriorating Health May Be Advantageous

The patient next in line may miss out if another patient begins dying quickly and is given higher category priority. That person grabs your donor's heart and you're waiting for the next car smash. But if a patient ahead of you becomes too ill to undergo surgery, or simply dies, or gets a cold that precludes surgery for two weeks then you jump in laughing, though not too loudly.

The Waiting List May Be Harsher Than the Transplant

Getting to the top of the waiting list may involve years of having one's hopes crushed repeatedly. It may wreck what is left of your life and you might fail to make it to surgery, anyway. Dr J.A. Roberts, of the Royal Hampshire County Hospital in the United Kingdom, said that patients' lives could be destroyed by the emotional turmoil of waiting for a transplant, not knowing whether it will happen.

This isn't a joke because even someone dying over a period of years can have positive inner and outer experiences. Undergoing waiting list anxiety can destroy that stability and then the transplant may fail and the patient die, anyway. Was the process worth it?

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". Two recipients are ahead of you. The first is undergoing theatre preparation at the hospital.

This is mind-breaking tension and you may find yourself hoping those ahead of you die suddenly or develop minor infections that temporarily preclude them from surgery. During pre-transplant immunosuppression,

or after the graft, a minor infection can become a deadly illness and kill the patient.

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

Finally, the good word arrives. The other two have dropped out for unspecified reasons. You're in the ambulance heading for the hospital. A fourth patient comes on line who hopes you'll be precluded from surgery.

Final Donor Organ Disease Checks

The donor is declared brain dead and moved to the surgery table but even now last minute disease checks continue. Did the donor recently work as a prostitute; if male has he had any homosexual activity since 1976? Donors can't have HIV-AIDS, evidence of prion diseases or other infectious agents. An exception is some nations approving donors with certain cancers and hepatitis conditions. The Americans are especially desperate to obtain organs though cancer usually precludes organ donating.

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

Previous transplant recipients cannot donate organs because the immunosuppression they've experienced has filled their bodies with powerful and diabolical diseases. Those having received Human Growth Hormone injections from pituitary glands taken from corpses preclude them from donating due to Creutzfeldt-Jakob (CJD) prion infection fears. Potential donors having lived in Great Britain for more than six months between 1988 and 1996 may be excluded in some jurisdictions due to Mad Cow Disease. Mad Cow prion diseases have incubation periods extending to fifty years.

Size Does Count

Transplants have been cancelled due to the shocking discovery that the donor's heart was too big. Donor organ size must be compatible with the recipient's organ size. Harvest organs are checked for abnormalities such as tumours. Small ones are cut off livers but if large or extensive the organ is rejected. Other harvest table nightmares include discovering the car smash that injured the donor's brain has also damaged the organs. Or the bullets that killed the donor have also pierced an organ. Surgeons might also ruin organs during 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 the minority. The majority fail to make the waiting list though on the positive side up to 9% are removed from the heart list because their health improves.

Preparation at the hospital involves paralysing and anaesthetising the patient similarly to the donor and hopefully the roles won't be confused. Surgeons won't remove the recipient's failing organ until they see and confirm the health of the harvest organ. They take this precaution in case the plane or car carrying the organ crashes or it may arrive spoiled or defective. An exception is when the patient is about to die anyway and the donor is in the same hospital.

Kidney transplants are easier. The recipient's failing kidneys are usually left in the body unless cancerous because removing even a failing kidney can cause heaps of new surgical problems. The new kidney is placed into the abdomen then connected from there to the renal system.

Inserting a third kidney into the abdomen is such a smooth operation that a recipient may be discharged from hospital before a living donor is released. Surgeons cut through muscle tissue and even saw off part of a rib to remove a living donor's kidney, far different than a relatively gentle insertion of the donor kidney into the recipient's abdomen. The living donor may suffer a collapsed lung and have a drain pipe inserted to help with re-expansion. Donating a kidney is no simple matter and the donor is left with a permanent body defect.^{114, 115} Laparoscopic or keyhole surgery avoids savage cutting and sawing and the kidney is squeezed out through a little hole. This apparently gentler method has dangers of kidney damage during removal and damage to the donor's ureter. The technique is far from perfected and very few surgeons perform this procedure well.

Living liver section donors suffer far more 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 liver section donors even die.

When the organ or part thereof has been excised it is then 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 difficult, 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. Nurses have reported being metaphorically “up to their knees in blood.”

Blood is now conserved by catching it in a trough, cleaning it and pumping it back into 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.¹¹⁶

Denton Cooley ranks along with Christiaan Barnard and Norman Shumway as one of the world's greatest transplant surgeons. He has performed numerous transplants without blood transfusion and is, predictably, a favourite 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 slips into a coma, suffers brain damage then dies. Even surviving can feel like losing. Mark Dowie has described the process 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.”¹¹⁷

Politics and surgery

British transplant survival rates are higher than American rates because they 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 received another blow. After two years of psychological agony while waiting for the transplant a doctor then told her she was too sick for a transplant and that putting 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 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.”¹¹⁸

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. These animal livers 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 flesh rots 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° Fahrenheit, which slows the metabolism, reduces its need for oxygen and slows the onset of brain damage. An anaesthetised and chilled body has a slowed metabolism which helps prevent both rotting and reacting to the knife. The anaesthetist is the theatre “stage-master” poisoning the patient to the edge of death but still alive.

Surgical procedures have improved since Washkansky's 1967 transplant but surgeons still can't avoid the fundamentals of transplanting. 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. An excised 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 when running a pump dry.

A transplanted heart requires a jolt of Direct Current electricity to get it beating, just like Frankenstein's monster. The present day process is more reliable than during Washkansky's time because heart harvesting now begins while the organ is still beating inside the donor. Previously, hearts removed after the donor had died wouldn't always restart or would not beat properly because of damage sustained during the lengthy dying process.

Patients with Two Beating Hearts

In the early days some surgeons averted the risk of patient death by leaving the old heart inside. This was called the "piggy back" transplant procedure - where the diseased heart was left in situ, in parallel, to do what it could. Relieved of the total load, it might recover - as happens nowadays with the LV assist device idea.

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, another man had lived 17 years with two hearts.

What If The New Organ Doesn't Work?

The reader might be wondering what happens on the operating table when a transplanted lung, heart or liver fails to function. Couldn't the patient continue living until another organ is located?

Theoretically, this is possible but the cost of keeping patients alive for weeks or months on heart and lung machines, or by 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.

It isn't worth the trouble so when a transplant of this sort has obviously failed theatre staff may turn off the patient's oxygen then stand quietly without speaking for a few minutes until death. This is cheaper, less degrading and less painful for the patient, and a form of euthanasia.

However, those buying Chinese organs get a special deal: if the transplanted organ fails the Chinese offer a replacement guarantee within one week. No problem for them: they have heaps of "donors" waiting to be chopped up.

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 fluid drainage and cleansing.

The Transplanted Heart

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

A normal heart increases beats to meet higher energy demands but when an organ recipient stands up the transplanted heart fails to speed up 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 from the brain to the transplanted lungs and heart though this explanation remains a theory.

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-owned hearts is their rapid deterioration. Coronary arteriosclerosis appears in 90% of transplanted hearts within five years. Those with their own original hearts receive by-pass surgery to remedy this problem but those with transplanted hearts can't get this procedure. They may even require another heart, if one is available. This is called a re-transplant and the survival rate is lower than for the first transplant.¹¹⁹

Long Term Recovery

Neurotics and hypochondriacs may find their transplant a dream come true. Illnesses and deadly diseases will spring up like mushrooms after a warm damp night. They will require a constant series of antibiotics and other drugs to fight germs the suppressed immune system can no longer battle. The patient's infection fighting capabilities will be too compromised to share coffee cups and it will be wise to avoid public toilets or those with colds. The organ recipient should not eat raw eggs, uncooked dough or lightly cooked meat. A scratch from working in the garden might easily turn into the patient's last infection on this earth. But at least doctors and friends will no longer deride the patient or laugh at new ailments because they'll be real and hypochondria a survival tool keeping the person alive.

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

The Surgical Procedure for Bone Marrow Replacement

Millions of people are waiting to become living bone marrow donors. The chosen few are admitted to hospital for removal of approximately half a litre of bone marrow from their pelvic bones. Recuperation entails a week in hospital 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 leukaemia-suffering recipient. The donor, once found, signs a contract agreeing to donate marrow within one week.

Doctors prepare the recipient by injecting poison drugs and irradiating bone marrow inside his or her bones. This kills the bone marrow and the patient will die in one week unless the donor fulfils the contract. The donor can theoretically murder the recipient and get away with it however the injected marrow is more often the culprit. It hates the recipient and its anti-bodies may rise up in what is called graft-versus-host disease and this kills its new host.

Another problem is the patient's cancerous bone marrow cells surviving the irradiation. It takes just a few surviving cells to recolonise the donor marrow and the patient is back to square one. It's a war and transplant recipients face a day-to-day struggle where life is never again assured.

Inga Clendinnen describes it eloquently 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."¹²⁰

Transplant organ prices in the United States and China

Transplant prices in the United States in US\$ 1996.		
Organ To Be Transplanted	Cost To Transplant	Annual Maintenance Charge in United States (UNOS) 1996
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

China transplant prices using organs from criminals and dissidents 2006. ¹²¹ Prices in U.S dollars. Annual Maintenance costs are based on postoperative care in the United States.		
Organ To Be Transplanted	Cost of Transplant in China (2006)	Annual Maintenance in United States (UNOS) 1996
Heart	130,000 to 160,000	21,200
Liver	98,000 to 130,000	21,900
Kidney and Pancreas	150,000	16,900
Liver and Kidney	160,000 to 180,000	N/A
Kidney	62,000	15,900
Lung	150,000 to 170,000	25,100
Cornea	30,000	N/A

Another more current source quotes, "... transplant in the United States costs between 250,000 to 800,000 dollars, depending on the type of organ).¹²²

Chapter 20

Religion, Culture and Harvesting

A keen feature of transplant agency promotion is their "dispelling the myths" leaflets 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.

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

Religious recommendations of donating a dead body so others can live rarely equate with harvest and transplant processes. A healthy human letting harvesters remove a healthy kidney and inserting it into the abdomen of a sick person appears the action of a saint, commendable by any religion.

But other facts should be considered. The previously healthy donated kidney will become sickly and probably fail within seven or eight years and the patient want another. Many recipients won't experience a sparkling new health but will suffer a series of immunosuppression generated illnesses. Their desperation to improve the health level of their carnal lives appears not the sign of someone who believes in life after death, but rather of someone who lacks spiritual faith. Someone desperate to hang on to any sickly state, at any cost, rather than allow their earthly body to perish.

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 that The Church supports organ transplantation with the Holy Scriptures being the final authority. He added 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."¹²³

This requirement of full informed consent contrasts with South Australian and other legislation around the world. The strict letter of the law says harvesting approval doesn't always require donor consent and a bureaucrat can order it with family consent only. If next of kin aren't contactable within an undefined "reasonable period" a government bureaucrat can decide to harvest without their consent. The crucial clause in much legislation rests on whether the bureaucrat hasn't a reason to believe the deceased would have been against donation. While

this draconian rule is rarely put into practice it would clearly conflict with Church of England policy as interpreted by Dr Claxton. As for his view that consent for harvesting should be obtained from the family of those signing donor forms, this has been overturned by all Australian State governments in 2005. Harvesters no longer need to or seek consent from families. In 2007 Dr Claxton no longer represents the Sydney Diocese Secretariat in this capacity and referred me to Andrew Ford who wrote, "At this time there is no official policy on this matter, however this doesn't mean that we are uninterested in this type of issues."

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 processes.

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. The Pope also said that the declaration of "brain death" must involve *"the complete and irreversible cessation of all brain activity (in the cerebrum, cerebellum and brain stem)"*¹²⁴

Australian harvesting practice contravenes the Pope's guidelines because it doesn't require electroencephalograph (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."*¹²⁵

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"*¹²⁶

Kidneys and corneas aren't sold in Australia or in most "developed" countries but governments are open about the financial benefits of these procedures. 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. As for bones, skin, tendons and other body parts, they are clearly commercial products.

The Jehovah's Witnesses

The Jehovah's Witness faith forbids the taking in of blood but not bodily tissue. If an organ is cleansed of blood and no transfusion is performed during surgery then accepting a transplant organ would meet their standards.

Donating an organ would require the same avoidance of transfusions during the excision process. This might require a ruling by their experts in the case of "brain dead" Witness donors receiving transfusions during the donation process. Would the "brain dead" Witness be really dead or not?

Storing blood for later use is also taboo in the Witness faith, however, collecting a patient's blood during surgery then transfusing it back meets their requirements.

The Jehovah Witnesses have produced a DVD showing how surgical teams can perform major surgery without blood transfusions.¹²⁷

The Eastern Church (Greek Orthodox)

Even the donation agencies are wary of stating that the Greek Orthodox Church supports organ donation. 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 the physical and spiritual bodies, but the idea of being buried with parts missing is seen by some as unpleasant at best.

Dimitri Kepreotes, Secretary to Archbishop Stylianos of the Greek Orthodox Church in Australia, wrote to me in 2002 saying that His Eminence is considering the matter and will consult expert medical opinion. But as of 2007 I have been unable to get a clear statement from the Church.

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. Our death, sooner or later, should not be seen as a disaster, but merely a change of consciousness. Therefore, the somewhat harsh act of removing a donor's vital organs then using vast resources to fit these organs into other bodies appears an act of ego delusion, which may indicate ignorance 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 that make up our being dissolve into the vast universe. The element of prana dissolves into the consciousness at the Heart Centre. Then the white Tig Le in the Head Centre descends and the Red Tig Le in the Navel Centre rises and the two 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.¹²⁸

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 meditation throughout their lives to dissipate crudity and delusion and to achieve clarity and retain it during the dying process.

Dying practitioners should be free from anti-psychotic drugs like chlorpromazine that may be injected during organ harvesting. The raising of blood pressure and heart beat as the surgeon's knife cuts into the donor's body might dramatically and detrimentally cloud the process of the transformation that we call dying. This would be especially disturbing if an element of consciousness remains within the body during the evisceration process.

Thailand

In Thailand 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 guilty for murder and corruption. The government allegedly also keeps a regular store of Falun Gong organ "donors" kept healthy until foreign "organ tourists" arrive with money. No waiting list.¹²⁹

The earlier method was to shoot a healthy "donor" to produce the "brain death" condition. The "donor" was shot in the head when the heart or torso organs were required and in the heart area when eyes were being purchased. Kidneys were removed from one prisoner then he was shot rather than the other way around.¹³⁰ But medical progress finally arrived and now they anaesthetise and paralyse the patient then cut out the organs and throw the carcass into the hospital incinerator.¹³¹ Being a donor is synonymous with being a victim or a loser.

Shinto (Japanese)

Shinto has a direct religious doctrine against organ harvesting and transplanting.¹³² 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 Japan's population.¹³³

Despite being swamped with dialysis patients harvesting is almost non-existent in Japan. The nation has advanced medical technology and allows kidney removal from completely dead donors upon family consent though just eight sets of kidneys were obtained this way in 2000.

Japanese patients become "organ tourists" and travel overseas to buy kidneys and other organs.

Gypsy

Gypsies include a range of peoples originally from India who have lived in the Balkans for centuries. They're a puritanical, travelling people who range though Europe, North America and Australia. "Gypsies have direct religious doctrine against organ donation"¹³⁴

Church of Scientology

Janine Werneburg 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.¹³⁵ The Church also has a strong policy against psychiatric and mind-altering drugs that may be administered to "brain dead" donors.

Hinduism

The great Swami Yogananda experienced the problems other people have in determining when death has occurred. He went to the United States of America to spread his spiritual teachings. At the height of his success in the early 1950's he went into sublime Samadhi and entered the traditional suspended animation. All bodily functions stopped yet his body stayed fresh because Samadhi transcends the process of life and death. His American followers at the Self-Realisation Fellowship didn't understand Samadhi. They thought he was dead so they cremated him. The Swami's more spiritual followers returned from a lecture tour and asked the whereabouts of their spiritual master. They were shown a pot of ashes.

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 crude testing of reflexes and bodily reactions is seen by many as simplistic and childish.

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 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 when the person dies. Blood donations aren't allowed in Orthodox Jewry. During the Arab wars some Jewish soldiers wouldn't donate blood either as this went against their beliefs.

Hmong

The Hmong 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. Their religious beliefs forbid mutilation of the body, "...including autopsies or the removal of organs during an autopsy," otherwise the soul may be doomed to hell.¹³⁶

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 – witchdoctors who enthrall people around the world with magic spells and spirits. The Pitjantjatjara people of inland Australia have Ngangkari who cleanse the souls of patients whilst in the "dream state". Feather Men and those who "Point the Bone" also inhabit the worlds of Australian Aboriginals.

Scientific Bogons (Zombie)

The Haitian scientific Bagon is employed by someone who wants zombie slave workers or to rob an enemy of their "soul". The Bagon 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. The Bagon returns and digs up and revives the poisoned victim to a semi-conscious state. The victim often suffers permanent brain damage from the poison and from oxygen deprivation while inside the 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 and occasionally escape though rarely regaining a sense of self.

Occult Bogons

Many Africans around the world believe occult Bogons cast spells to steal peoples' spirits. A person may hire a Bagon to attack an enemy. The victim loses a sense of self, 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 strong in places where bodies are often found with parts missing. Some say it's the result of attacks by organ robbers while others say it is Hoo Doo bogons stealing their victims' spirits that reside in certain organs.

When transplant coordinators pressure African-Americans to allow vital organs to be cut from the breathing, pulsing bodies of their relatives, well, it echoes back to the sound of a threatening Bagon chant.

Chapter 21

The Politics of Suppressed Death Statistics

Australia

The Australians began hiding patient survival statistics just before the end of the last century. They had been published in the Australian and New Zealand Organ Donor Registry Annual Report (ANZOD) then excluded.¹³⁷ Why would they remove such crucial data?

I asked this of then co-editor of the Annual Report, Karen Herbertt, in 2001 and she said they were short staffed and couldn't compile the data, an apparently reasonable response considering stagnant hospital budgets. Yet this was contradicted by the inclusion of complex data in her ANZOD 2000 Annual Report, data costing far more to collect than basic survival rates.¹³⁸

This data included ages of donors and recipients, gender, occupation, ethnic origin, religion. It included virology screening, cardiopulmonary resuscitation rates, smoking and drinking status, refusal or consent of donor families, weight and health of donors. Also, the age of unsuitable donor kidneys, terminal serum creatinine and urea levels in donated kidneys plus the oliguria and hypotension effect on kidney graft survival plus pages of similar data for other organs. It included 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 donor's life.

The ANZOD editors included tables listing drugs used to maintain harvest organs and hospital origin of donors. It included reasons for donor deaths: 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, swallowed an apple and strychnine poisoning.

It's fascinating reading but fails to provide an overview of transplant effectiveness. Simple survival data would show whether life expectancies of organ recipients are increasing, how Australia compares with other countries and whether previous figures were falsified.

Why Hide High Survival Rates?

Why would they decide in 1997 to stop publishing survival rates in the ANZOD Annual Reports? A cynic might suggest that reliable statistics give critics more ammunition for asking questions. For example: Are deaths counted only if they're reported to the transplant organisations? What about deaths from other causes? What is the standard statistic error estimate? What was the survival rate

of those who missed out on a life-saving transplant? One would expect these issues to be easily, if not eagerly clarified.

I contacted the ANZDATA Registry in Adelaide. They publish the ANZOD Annual Report. Professor Graeme R Russ was then co-editor with Karen Herbertt. He made vague noises pretending he didn't understand what constituted survival statistics. He said ANZDATA were too busy and my request would go on the slow queue and cost a hundred dollars to print two pieces of paper. Even that didn't happen. This was back in 2001. I approached ANZDATA again in 2006. They were better this time. Lee Excell provided some data and other people to contact though she wasn't wild about sharing data, either.

Matthew Hee, at the government funded “Australians Donate” organisation, copied Russ's vague mumbling then added high-pitched giggling sounds. He passed the buck to colleague Bruce Lindsay who was never available due to attending to personal needs or in a meeting. Other Australian donation agencies responded similarly – high pitched giggling from men; hostility and aggression from women.

Karen Herbertt has left the South Australian Organ Donation Agency. You don't know how good someone is until they're gone. The Agency has since left its shopfront office in Adelaide's hospital/university precinct. They've retreated to the business section where the receptionist hides behind slits of protective glass.

The Mythical 90% One-Year Survival Rate

Australian organ donor agencies use promoters to give lectures in schools. They avoid quoting precise data claiming instead a 90% one-year survival outcome for vital organs. They call this their “ballpark figure”. 90% is accurate for kidney transplants but this claimed 90% one-year survival rate for other vital organs such as pancreas' and hearts appears deception.

Australian 1997 heart transplant survival statistics were published by the government agency, *ACCORD*, (since replaced by the mysterious *Australians Donate*). *ACCORD* claimed an impressive one-year 90% survival rate for heart transplant recipients.

Incredibly, the German one-year survival rates listed in Mario Deng's study, *Effect of receiving a heart transplant: analysis of a national cohort entered on to a waiting list, stratified by heart failure severity* were 71% for the years 1997-2000. The Henry Mondor Hospital in Paris with its large and experienced cardiac transplant unit was even lower at 62%.¹³⁹

Deng's conclusions were corroborated in the United Kingdom by the Clinical Effectiveness Unit of The Royal College of Surgeons of England. They 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% [of these] had died,…” while the three-year survival of those not getting a transplant was: “...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.”¹⁴⁰

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 claimed 1997 Australian 90% one-year survival rates indicate? The answer is simple: the government agency, ACCORD, was lying. So were the organ donation agencies quoting this figure in schools.

But things haven't changed and government funded registries obfuscate the simplest survival data. The Australia and New Zealand Cardiothoracic Organ Transplant Registry (ANZCOTR) doesn't print stand-alone one-year survival rates in its 2005 Report. They mix one-year results with the previous twenty years then average them out at 83.9% leaving us none the wiser as to the most recent one-year survival rate.¹⁴¹ I asked Ross Pettersson at ANZCOTR for the latest one-year data but he said was too busy to provide them.

The politics of heart transplanting

Mario Deng's team concluded that only patients with a high risk of dying while on the waiting list improved their life expectancy with a transplant. Those with medium and low risk of dying while on the waiting list didn't improve their life expectancies with a heart transplant. So why bother giving them new hearts?

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 due to their general bad health when compared to those of medium and low risk who, perhaps, got heart transplants that weren't necessary. This would reduce the average life expectancy of heart transplant recipients to such low levels that the public might question why we as a society bother with the procedure.

To dissuade the public from asking this question scarce hearts are transplanted into less desperate patients 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.¹⁴²

This begs the question that waiting lists might be padded with people who could benefit more from other forms of medical treatment.

Chapter 22

A Short History of Human and Xeno Transplanting

Human Transplant History

1700: Human skin was transplanted to burns, disease and injury victims in India.

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

1905: Human blood was transfused into other humans with bad results because blood types weren't distinguished.

1905: Dr Eduard Zirm performed the first successful corneal transplant. It restored the sight of a man blinded in an accident and was performed in the part of Czechoslovakia now known as the Czech Republic.

1933: Voronoy, a Russian living in France, performed the first recorded human kidney transplant without the benefit of tissue typing. It failed.¹⁴³

1954: First successful human kidney transplant.

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

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 and verged on being a sex maniac. He screwed three separate women in one night, had two women at one time and also did it to Italian actress Gina Lollobrigida. His first wife committed suicide, 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 his refusal to abandon his country.¹⁴⁴ Barnard was famous and respected world-wide but not particularly so amongst his medical peers. Some say he was more interested in fame and fortune and cared less for his patients.

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 immunosuppressive drug used in transplantation.

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 into 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 transplant using organs harvested from "cardiac dead" donors. Performed in Sweden. Lungs are still removed mostly from "brain dead" donors.

Xeno History

1628: Sheep blood transfused to humans in Padua, Italy.

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

1800's: Sheep blood injected into wayward husbands and troublemakers in England 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: Prinçteau'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.¹⁴⁵

1913: Serge Voronoff transplants chimp thyroid 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.¹⁴⁶

1920-1923: Serge Voronoff does a series of testicle transplants from monkeys and chimpanzees to elderly men who reported renewed vigour.¹⁴⁷ His achievement was celebrated on ashtrays engraved with little jokes about improved performance.

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. Shumway was a superior surgeon to Christiann Barnard and had more concern for his human patients. He was capable of beating Barnard to the first human heart transplant but knew that organ rejection would kill the recipient and was reluctant to proceed until that problem was more understood.

1963: Keith Reemtsma of the United States 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 the surprise when they discovered their child got a chimp's heart. The kid died during surgery.¹⁴⁸

1965: Tom Starzl, aka Tom 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 set of kidneys produced fifty litres of urine in 24 hours, which killed the patient.¹⁴⁹

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 transplanted 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 when their own hearts failed to recover.

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. Dr Bailey 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 human and xeno transplanting.

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

1993: Leonard Makowka put a pig liver into a human. It failed.

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: Pig heart transplanted into a human in India. Patient died and the surgeon was jailed. When he got out he said he was going to do more.¹⁵⁰

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 onto the performing of transplants between different animal species and, predictably, things 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 coma patient with liver failure. The sheep's liver cleansed the man's blood and he awoke full of vigour, but in what 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 having heard the sheep story, covered the baboon so as not to distress others and sedated both the baboon and the 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 monograph, 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.¹⁵¹

Chapter 23

Trusting Your Hospital

If you use Frankenstein medicine you get Frankenstein results.

Professor Lynette Dumble¹⁵²

In 1958 an American named Raben obtained human growth hormone (hGH) from pituitary glands removed from corpses. The pituitary is a pea-shaped gland located in a bone cavity at the base of the brain. It stimulates growth, especially in adolescents, and when the gland is defective, children remain short and women infertile. Short children who ate the corpses' growth hormone grew to normal height and infertile women doing the same became pregnant.

When Australian professionals are caught acting despicably they often blame their behaviour on American influences. Yet during the history of the Human Growth Hormone program American doctors were frank and open, telling their patients hGH was obtained from corpses. Australian doctors deceived their patients saying the hormone was from a "natural source". Dead bodies may be natural but eating parts of them is not.

The Australian Human Pituitary Hormone Program began in 1965. The Commonwealth Serum Laboratory (CSL) managed the operation by collecting the glands from morgues throughout Australia then processed 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. They instead approached the pathologists doing post-mortems, theoretically, for education and research purposes only. Autopsy consent forms didn't always include the right to remove organs but many pathologists did so anyway.

This 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, overtly in the interest of science, but organs and body parts were removed covertly.

The CSL still couldn't obtain adequate supplies of glands in Australia because pathologists were reluctant to become involved not wanting to land in a legal and public relations nightmare. In response the CSL bypassed 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.¹⁵³

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..."¹⁵⁴

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."¹⁵⁵

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."¹⁵⁶

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..."¹⁵⁷

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 from relatives, was not consent to remove organs. No one was ever charged.¹⁵⁸

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."¹⁵⁹

171,091 pituitary glands were removed from Australian corpses from 1965 to 1985. The practice stopped when American scientists warned that infected pituitary glands were transmitting Creutzfeldt-Jakob disease prions. 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

Dr McGovern was a leading Australian neuro-pathologist of his day and a member of the Human Pituitary Advisory Committee. He repeatedly advised the Commonwealth Serum Laboratory (CSL) that glands should not be used where death was caused by "slow viral infections". These included Creutzfeldt-Jakob and Alzheimer's Diseases. The government removed Dr McGovern from the advisory committee in 1976. The CSL "accidentally" removed his infection warnings a year later and then recommenced using pituitary glands despite prions being a possible cause of death.¹⁶⁰

Jane Allendar

The callousness of medical professionals could hardly be more distastefully displayed than in 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 on Jane was derived from human corpses, some of whom had died from Creutzfeldt-Jakob or similar prion diseases. These were the types of corpse for which Dr McGovern had issued his warning.

It wasn't just the fact that Jane Allendar died due to medical negligence but the 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. They also knew that she would die a slow, horrible death. They didn't tell Jane or Ted Allendar anything to protect their own interests despite persistent efforts from the Allendars. They eventually sent a nurse to coldly inform Jane, near the end of her life, that she had a terminal illness, cause unknown. But these medical bureaucrats knew all along.

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. He discovered the cause in passing at an Administrative Appeals Tribunal Hearing in Adelaide. Creutzfeldt - Jakob disease prions had killed Jane and had come from her fertility treatment derived from corpse glands—and that the doctors and bureaucrats had known for years before her death.^{161, 162}

Building Distrust in Japan

You can't blame the Shinto and Buddhist religions solely for the unpopularity of organ donation in Japan. Juro Wado helped.

Dr Wada was Japan's first heart transplant surgeon. His donor was an eighteen-year-old drowning victim. Wada's first mistake was declaring the boy dead instead of getting an independent assessment. His second mistake was putting the boy's heart into a patient who didn't appear to need one and whom subsequently died twelve weeks later. An investigation indicated the patient needed a simple valve replacement and not a heart transplant.

Then the deceased patient's original heart disappeared and when found later was missing its valves. These were found elsewhere but when examined one valve had a different blood type suggesting an attempt to confuse the investigators. Dr Wada blamed the misplacement of the valves on a younger surgeon who had conveniently died of gastric cancer and couldn't defend himself.

The Japanese prosecution charged Dr Wada with double murder. The first charge was that the donor hadn't been proved dead before harvesting. The second was

that the deceased recipient had needed a simple mitral valve replacement and not the full transplant that killed him. The case dragged on for years and Dr Wada finally escaped conviction when all charges were dropped.

Further similar incidents followed leaving the Japanese public with major suspicions of transplant medicine.

Chapter 24

Organ Selling, Organ Theft

"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."

Nancy Scheper-Hughes¹⁶³

You might have heard the "myth" about the man visiting a bar in a foreign country and being invited for a drink by a young woman. He wakes up next morning in a hotel room with a thank you note and two sewn up wounds from where his kidneys were extracted. This often repeated tale might have taken place in any exotic city in the world. Harvest promoters minimize and cloud the reality of the organ trade with these exaggerated tales. Their unreliability is used as proof that organ theft is of minimal concern.

The reality is that it is cheaper and easier to pay an impoverished person a few thousand dollars for a kidney than create an elaborate organ theft scheme. An organ seller doesn't need to be trapped or imprisoned but will wait patiently while disease and tissue matching tests are completed, and the organ tourist prepared. A vast network of organ brokers concentrate on Pakistan, India, South Africa, Peru, Romania, Bolivia, Brazil,¹⁶⁴ and China as source destinations. Buyers arrive from the richer European countries and Israel, United States, Canada, Australia, New Zealand, Japan and some Arab countries. Buying an organ requires money and lack of conscience. Selling requires a sense of despair and hopelessness. Following are a few examples of the organ trade.

India

The police in Amritsar city in Punjab state, India unearthed what they call "the mother of all scandals in human organ trafficking in India."

Indian organ sellers were paid less than \$US1000 for a kidney then didn't receive adequate post-operative care. They were threatened with imprisonment for breaking the law prohibiting organ selling if they complained to police. At least six died of post donation complications.

The police have arrested several doctors, middlemen, and donors, including the alleged main player. He is transplant surgeon, Dr Parveen Kumar Sareen, who works for Kakkar Hospital which is run by a private charitable trust. Also arrested was Dr O P Mahajan, principal of the Government Medical College and chairman of the authorisation committee that certifies that no commercial transaction has taken place.¹⁶⁵

United States of America

Bart Wheatley of Intermountain Donation Services in Utah obtained the body of a young man who had committed suicide. He wasn't fazed that the body had lain in the victim's bedroom for nineteen hours without refrigeration. Twelve hours is the safe limit otherwise *Clostridium sordelli* bacteria might have broken through the intestinal walls and contaminated the body.

However, business is business and Wheatley sold parts of the body to CryoLife in Georgia for \$10,500. CryoLife's cost cutting program had reduced testing for body parts bacteria, which was bad news for Brian Lukins, a patient at St. Cloud Hospital in Minnesota. He thought he was getting a simple bone transplant into his knee. So did Dr Mulawka, his surgeon.¹⁶⁶ The problem was the dead guy's bone was infected by *Clostridium sordelli* bacteria. It entered the blood stream of Brian. He felt really bad, turned grey and then died.

Alistair Cooke did much better. He was the famous British/American journalist who died of cancer in 2004 at the age of 95. He was dead just twenty-four hours when morgue operators were already ripping out his bones, illegally. No one knew this until police discovered Cooke's funeral directors were involved in a stolen body parts racket. If this can happen to a famous dude like Alistair Cooke imagine what might happen to us less famous people.¹⁶⁷

The United States Food and Drug Administration recently shut down body collector, Donor Referral Services in North Carolina. They said donor records did not match death certificates that listed cancer and drug use. It was a case of mutton dressed up as lamb so to speak.

The FDA and the Centres for Disease Control and Prevention recommended that doctors offer hepatitis B and C, syphilis and HIV tests to those having received corpse material harvested by the company.

Phil Guvett, spokesman for Donor Referral Services has denied any wrongdoing.

Presumed Consent in Los Angeles

Governments rarely broadcast their presumed consent laws. Why panic the population who might rush to become organ keepers. Governments instead harvest body parts surreptitiously without prior permission of either the deceased or next of kin. They don't even inform relatives that harvesting took place. This quiet process was interrupted in Los Angeles when Doheny Eye and Tissue Bank was caught harvesting the corneas from the body of shooting victim, Ralph Frammolino. Ralph's sister and parents registered their objections to donation the morning after his death, but the harvesters rose earlier and had already grabbed his corneas. They paid \$250 then sold them to a transplant institution for \$3400.¹⁶⁸

The American states using presumed consent are California, Florida, Hawaii, Kentucky, Louisiana, Maryland, Michigan, North Carolina and Wisconsin.

In one group questioned in Kentucky just 6.6% knew that presumed consent laws existed despite being enacted for ten years.¹⁶⁹

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 return the bones. Greg and Lucinda Ramirez sued the Red Cross but it was not until two years after Heather's death that the bones were returned. Red Cross spokesman Mike Fulwider said, "We are certainly deeply saddened by this," He didn't say whether the sadness was due to the theft of the bones or from being caught.¹⁷⁰

Lack of Respect

17,500 bodies are donated for medical and research testing in the United States annually. This is on top of 5500 "brain dead" and 20,000 cardiac dead donors. The bodies donated for medical research are used by surgeons and students for practice sessions and as surgery models at conferences. Four thousand bodies go for experiments including putting heads in helmets and then dropping them from a height to test the helmet's strength. Other bodies are strapped into 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 because, as Russel Sherwin of the University of Southern California says, too many objected.¹⁷¹

Funeral home owner John Vincent Scalia bought nine bodies from the Louisiana State University and the Tulane School of Medicine for which he paid the latter \$8640. Scalia resold them to the United States Army for \$37,485. The Army used them for testing ballistic body armour in land mine experiments.¹⁷² The Army video of the testing could be titled, "Whatever happened to Grandpa?"

Back in 1996 the University of California Los Angeles suffered a class action by donor families whose relatives' bodies had been donated for research. The University had promised when finished with the bodies to either bury the remains or scatter the ashes after cremation in a rose garden. Donor families were unhappy when they discovered UCLA had burned them in piles alongside medical waste then sent the ashes to a landfill.¹⁷³

China

"The bodies were thrown into the boiler room at the hospital,"¹⁷⁴

Most people understand that China sells organs from executed prisoners to wealthy foreigners. You simply locate a broker, pay the money and fly to China. Why wait four years for a kidney when you can get one in two weeks. You undergo immunosuppressive treatment while they choose the right prisoner. Two living humans enter the surgical theatre and one comes out alive.

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."¹⁷⁵

Testimony is also emerging that members of the Falun Gong religious movement are the latest source of organs for the Chinese transplant industry. Young Falun Gong prisoners are allegedly initially beaten then suddenly treated like hospital patients undergoing tests. Organs are also harvested daily from prostitutes, Tibetans, political dissidents, and criminals.¹⁷⁶

China doesn't have an organ donation system like the richer countries. There are rare instances of kidney donation within families plus a dozen voluntary "brain dead" donations have been performed overall, but this is from a population of 1.3 billion people. The Chinese believe that being a voluntary organ donor sounds as logical as becoming a voluntary prisoner: it doesn't make sense.

Australia

Organ selling is illegal in Australia but those caught doing it receive a paltry fine of \$5000. The fines are being updated, belatedly, with little zeal. Media liaison professionals operating within government departments manage organ donation promotion activities while public servants are prohibited from speaking to the public. State governments don't promote kidney selling but quietly turn a blind eye to suspicious "donations". As stated above, Nick Ross "donated" a kidney to his billionaire employer, Kerry Packer. The Royal Prince Alfred Hospital ethics committee approved the surgery after which Packer donated \$10 million to the hospital. The hospital refurbished their kidney clinic with Packer money then named it after Nick Ross. The hospital and the New South Wales Government refuse to discuss the ethical aspects of the donation.

Australians buying organs overseas slip even further into the shadows of government minds. There hasn't been any attempt by the government to keep track of Australian organ tourists. Dr David Filby, an inter-government liaison executive in the South Australian Department of Health wrote me saying, "It is known/suspected that some Australians do travel overseas to obtain organs but details about this are scant or the subject of rumour."¹⁷⁷

Pathologists were caught in Queensland in the 1980s taking heart valves during post-mortems that were legally limited to discovering the cause of death, but not for body parts harvesting. Post-mortems have been a traditional Australian method of obtaining body parts.

Professor Margaret Allars corroborated this practice saying non-coronial post-mortems were used to illegally remove pituitary glands from corpses.¹⁷⁸

The Sydney Heart Valve Bank told me their heart valves are collected from cadaver donors via "Forensic and Coroner cases".

Post-mortem consent forms used in hospitals often have obscure clauses buried amidst the fine print agreeing to "tissue" harvesting. Relatives in shock could easily be fooled into signing away body parts thinking the post-mortem was to discover the cause of death only.

Back in 1989 harvesters asked Mike Wynne in New South Wales for consent to remove organs 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 consented for certain organs to be removed because the boy reputedly had wanted to be an organ donor upon death. Consent didn't include his nephew's eyes but the hospital took them anyway. Mike discovered this when they sent him a bill for X-Rays. What most offended Mike was the reaction from the hospital. "I was treated with complete disregard afterwards," he said. He also suspects his nephew had been moved to another hospital in preparation for harvesting rather than for treatment.¹⁷⁹

The Royal Adelaide Hospital in South Australia was admonished by State Coroner Mark Johns for using organ donation as an excuse for not being able to fully investigate the death of car smash victim, Cosmo Joseph Campanella, in December 2002. The hospital claimed the cause of death could not be determined because transplanters had whipped out the evidence as Mr Campanella was an organ donor.

Coroner Johns determined that death was due to a blocked breathing tube that caused the patient to suffer a fatal heart attack and that "...the hospital's argument might discourage future organ donation and is adverse to the public interest."¹⁸⁰

Anatomy Classes

The University of New South Wales has apologised to families of people whose bodies had been donated for anatomy classes. Allegations have risen that breasts were fondled and a head used for degrading purposes.

Chris Game, speaking for the National Tertiary Education Union, said a laboratory supervisor had long tried to alert authorities about his concerns.

The university's Deputy Vice-Chancellor Professor Richard Henry has denied there was a cover-up.¹⁸¹

Forensic Crime Tests

Professor Hilton repeatedly stabbed one body at the Glebe Institute of Forensic Medicine in Sydney to gain knowledge for a crime trial. Other employees belted the head of a crime victim with a hammer for investigative purposes. They also removed spinal columns for use elsewhere and performed nose jobs on bodies for practice. These were reasonable forensic and medical activities but next of kin weren't sought for permission.

Other Glebe Morgue employees stole clothing, shoes and personal affects from fresh bodies brought in from car smashes. The Morgue now employs non-doctors to remove bones from cadavers and sends them in cooler boxes to Australian Bio-technologies in Sydney for processing into bone paste and transplantable bone shapes.

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.

England

Dr Rasheed Ahmad, an Emeritus Consultant Nephrologist from Liverpool reports in 2006:

"...I am personally aware of a regular flow of patients from the United Kingdom to the so called Renal Belt comprising of underdeveloped countries and largely with poor outcomes..."¹⁸²

Israel/Palestine

Israel is arguably the world's leading procurer of vital organs from other countries, at least for its size. Just 3.5% of Israelis are registered organ donors. Their donor rate is one-fifth that of Europe so they acquire vital organs from other cultures.

The Jewish Diaspora provides an effective platform to broker organ purchases around the world. The Israeli government helps by paying up to \$80,000 each to those visiting other countries to purchase an organ. Brokers openly advertise their services on Israeli radio stations and in newspapers.¹⁸³

An American, "Jane Doe", describes herself as a "deeply spiritual woman". She used an Israeli broker to buy a kidney from Alberty Jose da Silva, a 37-year-old Brazilian man from a large poverty-stricken family. They met in South Africa for the surgery where Jane got one of Alberty's kidneys. He got \$6000 though was robbed of it upon returning to Brazil. South African police later closed down this organ-selling racket.¹⁸⁴

Professor Nancy Scheper-Hughes, in her statement to the Committee on international relations, House of Representatives in the United States Congress described another racket,

"Dr. Zaki Shapira, head of transplant services at Bellinson Medical Center near Tel Aviv...has been operating as a transplant outlaw since the early 1990s when he first used intermediaries and Arab brokers to locate kidney sellers amongst [cash]-strapped Palestinian workers in Gaza and the West Bank...Meanwhile, human rights groups in the West Bank complained to

me of tissue and organs stealing of slain Palestinians by Israeli pathologists at the national Israeli legal medical institute in Tel Aviv... in the late 1990s, Shapira [Dr Zaki Shapira of Israel] simply moved his illicit practice overseas to Turkey and to countries in Eastern Europe where the considerable economic chaos of the past decade has created parallel markets in bodies for sex and bodies for kidneys."

"Dr. Michael Friedlander, chief nephrologist at Hadassah Hospital in Jerusalem, tired of reports about commercialization of kidneys in Israel, decided, like Dr. Diflo, to speak out, and he says that among his recovering international transplant patients are several Israelis who have recently returned this year and last from the United States with kidneys purchased here from living donors."

"In March of 2001, I interviewed in Israel two men, one a young student and the other a retired civil servant, who had both returned to Jerusalem from transplant units in Baltimore and New York City, each with a brand new purchased kidney."^{185, 186}

Palestinians give organs of son killed by Israeli soldiers to four Jews and two Arabs.

Twelve-year-old Ahmed Katib was walking to a shop in the Jenin Refugee Camp on the West Bank on November 3, 2005 to buy a tie for a wedding that evening. He became involved in stone throwing at Israeli soldiers involved in a gun battle with Palestinian snipers and an Israeli soldier shot Ahmed in the head and stomach.

His parents, Ismael and Abla agreed to donate the vital organs of the mortally injured Ahmed and he was taken to an Israeli hospital where his lungs, liver, heart and kidneys were removed.

A Druze Arab girl got his heart, a Bedouin boy got a kidney and four Jews got his lungs, liver and the other kidney.

The father of the four-year-old Jewish girl who got one of Ahmed's kidneys said he wished it could have come from a Jew and not an Arab.¹⁸⁷

Is organ harvesting a spoil of war?

Organ removal is government retribution against criminals and dissidents in China. Has organ harvesting from defeated enemies become a spoil of war in the Middle East?

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 demonstration where stone throwers were fleeing Israeli Army soldiers. The soldiers grabbed Khader and beat his head and body with

truncheons. Shopkeepers shouted that Khader wasn't involved but soldiers broke one of Khader's arms 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 whereupon 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 inadequate paperwork. He was taken to Ansar Two prison and thrown into a prisoner tent holding thirty to forty prisoners. The other Palestinian prisoners 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 his 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.¹⁸⁸

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.¹⁸⁹

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.¹⁹⁰

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.

The Israeli government organises Moldavians to travel to Turkey where doctors harvest one of their kidneys for insertion into a waiting Israeli citizen.

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 interest neither the harvesters nor the organ recipients.

Russia

Four doctors were charged with attempted organ theft at Moscow City Hospital No 20, after police found the "donor" lying on a harvest table with his hands tied behind his neck. The victim's heart was beating and he had normal blood pressure. There wasn't a death certificate but the "donor", Mr A Orekhov, later died.¹⁹¹

Chapter 25

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", connected to a breathing apparatus, with a beating heart and warm and soft body into a grave? Would we then throw the dirt over her? Probably not. Yet transplant agencies suggest we hand over relatives to surgeons to perform multiple organ removal without anaesthetic while the donor is in similar condition.

Consider this conundrum.

A person with a knife runs into the hospital intensive care ward and slices the wrists and throat of this same "brain dead" woman. Blood sprays over the bed, her arms and legs flail about, her body convulses in pain and finally her heart ceases beating. Would we call this act abuse of a dead body or murder? Our innate feelings might be that it was murder though transplant coordinators could be called to appear in court as expert witnesses to argue that it was merely bodily abuse. Their expert opinion might reduce the sentence from execution to a good behaviour bond, or a "community service order", or a short stint in prison.

Two Types of Death Depending on Donor Status

Dying organ keepers are treated with more respect as their status descends slowly from "the patient" to "the deceased" to "the corpse" and finally as "the cadaver".

In contrast, the status of the donor drops 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 the harvesters yet the same behaviour to an organ keeper is acceptable.

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

Two Types of Patients

Stroke and head injury victims are categorised soon after hospital admission: donors and non-donors. Medical bureaucrats may deny it but prospective donors are watched with a view of protecting their worth as a source of body parts. When the patients' conditions decline doctors continue treatment but keep in mind the value of the harvestable organs. The prospective donors may get damaging treatment aimed at preserving their organs for transplanting while

organ retainers may receive a superior treatment designed to heal the damaged brain. Thus we have two types of patients: those who receive healing treatment and those who are 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 the joyful organ recipient notion requires an ignorance of the processes and results of transplanting—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.”¹⁹²

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.”¹⁹³

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 organs are transplanted into very few children and those few who do receive heart, lung and liver transplants are shockingly unhealthy and unnatural in appearance. One could ask whether it's an act of kindness to subject children to these ordeals.

The reality is that the donors tend to be younger than the recipients. Organs from young bodies transplant best. Recipients of kidneys are often over sixty years old while prospective kidney donors of this age rarely donate these organs due to degeneration.

Older recipients may spend their total estate that took a lifetime to accumulate for a heart or liver transplant, even with government funding. This is true in the United States and countries without national Medicare programs where ability to pay often determines whether a patient gets a transplant. 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 lifesaving procedures, but the industry has descended to less crucial 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. There is also evidence that those having breast enlargement surgery have a higher rate of suicide. This suggests that those seeking this surgery are mentally unstable or that ensuing suicidal feelings are the result of surgery, especially if it goes horribly wrong.¹⁹⁴ A friend

working in the lingerie section of an upmarket clothing store told me she's seen some real "boo-boos".

One might question the value of transplanting kidneys into middle aged or older patients who have ruined these organs through preventable types of diabetes, often caused by overeating fat and sugar, and not getting enough exercise. Others ruin their kidneys and livers through high consumption of alcohol and prescription drugs.

Common prescription and supermarket drugs including those containing acetaminophen x128 are still causing liver and kidney failures. Three dollars worth of paracetamol may cause acute liver and kidney failure resulting in death or need for a transplant. This is because the recommended dose is very close to the lethal dose.¹⁹⁵ One might also question the value of transplanting livers when the primary cause of liver failure is from Hepatitis C caused from drug injectors sharing needles.¹⁹⁶

Who Gets The Body Parts?

Those signing the organ donor registers assume that those most desperate and best able to regain health will receive their donated body parts. Few donors like the idea that their donation might 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 transplants the criteria of having plentiful post-operative care and housing is crucial. This excludes some of the poorest candidates.

But the major injustices occur with the distribution of body parts and products not vital to maintaining life. Government hospitals have long waiting lists for free, non-emergency surgery so patients dependent on these institutions have less access to body parts. Those with expensive insurance enter private hospitals for immediate treatment. This means the richer classes have easy access to donated cadaver skin, bone, ligaments, tendons, hormones and fascia 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. It has been introduced by raising subsidies for private hospital insurance 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 removed, which retained the status quo of distributing donated body products according to the ability to pay rather than need.

Ghoulis Nature of the Act

Melbourne writer, Inga Clendinnen, courageously noted the ghoulish aspect of waiting for an organ. She received a liver transplant and noted the thrill of the organ failure patient 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."¹⁹⁷ Mr Awaya 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 becoming semi-voluntary kidney banks for each other. They may be pressured emotionally or in rare circumstances taken to court by the person wanting the organ.¹⁹⁸

This Pandora's Box is driven by 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.*¹⁹⁹

The Hospital as Refuge

Transplant hospitals are like a garage you take your car for repairs then discover they've got an auto wrecking business at the back want to dismantle your vehicle for spare parts.

The introduction of staff trained to target relatives of "brain dead" patients reduces the security 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."²⁰⁰

Sociologist T. Awaya may be somewhat optimistic when he describes transplanting as "friendly" human cannibalism. 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.²⁰¹

The Splitting of the Human Species

Another hidden cost for the continual development of transplant technology is the need to perform unspeakable acts of research on millions of animals. These acts corrode human society because people can't openly admit their indirect involvement in research events that are often happening inside their hospital's grounds.

Before every surgeon attempts a new procedure he or she practices the technique on dozens of animals to attain the required expertise. The surgeon is then ready for humans.

While researching this subject I've read dozens of books and hundreds of websites and research papers on transplant surgery which contain references to dogs, baboons, monkeys, chimpanzees and pigs being used for transplant experiments. One sad reference is to the use of ex-space flight candidates and circus chimps for xeno transplant experiments because they've been trained to behave under stress, and their teeth have been removed.²⁰²

Each new report on improved transplant technology will involve many animals being subjected to transplants from their own and other species. Researchers tie them to beds or tables after surgery, often with little or no post-operative pain reduction, then calmly observe and measure the responses of these unfortunate creatures. They kill the animals afterward – sometimes with regret, other times with indifference.

The researchers are rarely disinterested observers. They're locked into academic achievement or involved in the commerce of biotechnology. Their primary aim is maintaining research grants and inventing profitable new products or procedures for the sponsoring pharmaceutical corporations.

Pigs are the prized potential source of organs for human transplants despite having less compatibility than baboons, chimps, gorillas and monkeys. Pigs walk on all fours, are too big and have hearts that pump most efficiently while the animal is horizontal. But the primates are slow to reproduce and mature and require plenty of varied, fresh and expensive foods while pigs are less fussy. Pigs also breed quickly and suffer less illness. But the main thing is that people dislike pigs; they don't look like us so few worry what happens to them. But why experiment on pigs when the contrast between them and us is so great that they probably won't be used as a source of organs? The answer may be DNA manipulation.

The transplant industry will need a creature more compatible, but humanity won't allow the raising of humans for spare parts. The industry may respond by developing a semi-human clone using stem cells and DNA material from other species. Humans will be mentally conditioned to believe that this development will cure deadly diseases forever and that semi-human clones lack souls and sentience. Mental conditioning or "brain washing" requires an element of fear and pain so the population may be terrorised, one way or another, to acquiesce to this division of the human species.

Tom FrankenStarzl

Tom Starzl failed to transplant baboon livers into humans in 1992 and 1993. In response drug companies shifted inter-species experiments to between animal species. Secret labs switch organs from larger animals into smaller ones and vice versa. The result is a forlorn monkey holding in its arms a large parcel connected to its body with tubes. The parcel contains a pumping baboon heart too large to fit into its thoracic cage. The unfortunate monkey understands that its life depends on protecting this alien pumping mechanism. Within the transplant "community" this technology is hailed as an example of an evolving science, but for humanity represents a downward spiral or devolution.

Maintaining Kidney Harvest Rates

The number of human kidneys harvested has been maintained despite next of kin resistance and reduced trauma injuries. Harvest protagonists achieved this by increasing pressure on next of kin, reducing the qualifications for "brain death", spotting donor candidates before their hearts stop, and by lowering the time periods between hospital admissions, "brain death" diagnosis and harvesting. Some countries like Australia and the United Kingdom have removed veto rights of next of kin.

Transplant protagonists hope to meet increased demand 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 keeper intentions have been stated.
- b) harvesting "vegetables" whose consciousness is subdued²⁰³ but the brain area which maintains bodily functions is alive and healthy (as distinct from someone "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 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 to chop up for stem cells. Another potential source not yet exploited is from aborted fetuses. Many foetal 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 fetuses are required to treat one patient and the treatment isn't permanent.²⁰⁴ The product of abortions may then become a crucial component of medical procedures and the reasons for abortions may be subverted to biotechnology interests. We may then find ourselves in a position of maintaining production of aborted fetuses and invitro embryos to feed the transplant 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 potentially poisonous food, force the lowest status rat to test it while the others wait to see if it dies. Or these same rats during a famine when one-by-one they eat the weakest rats until there might be, when the drought breaks, just a half-dozen King and Queen rats remaining. Except that we humans aren't in famine: we're victims of our own Pandora's Box technology.

Human families are now reacting differently to sick members. We are seeing a guarded reaction, particularly from the lowest status family members, 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 family may even seek a "compelled donation" via the courts. 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 it is clear that we are descending into a cannibalistic society. It remains to be seen where ideological and organisational resistance to this trend will arise.

Appendix One

Testing for Brain Death

Some comments on special techniques by 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 *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”. The same is true of *elegant EEG techniques* which look for “evoked potentials” - demonstrable responses to various stimuli which may indicate that there is still functional activity in, for example, brain stems which have been declared “dead”.

Other sensitive diagnostic techniques, such as *magnetic resonance imaging*, are being developed and may well have the power to detect continuing life in brains pronounced “dead” on the basis of the simple bedside tests in current use.

Appendix Two

Treating Brain Injury

Some comments by 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 treatments aimed at 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 keeping 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 hanging 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.

¹The Weekend Australian newspaper. ***Gentle Persuader*** by Roy Eccleston. 9 August, 1997

² See Hoffenberg R. *Christiaan Barnard : his first transplants and their impact on concepts of death*. *British Medical Journal* 2001;323:1478-80).
<http://www.bmj.com/cgi/content/full/323/7327/1478#References>
Accessed 9 May 2007

³ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. ***Beyond Brain Death***. Kluwer Academic Publications, London, United Kingdom. 2000

⁴ Taylor R. ***Re-examining the definition and criteria of death***. *Seminars in Neurology* 17(3) 265-270. (1997)

⁵ The file containing "brain death" testing procedures is at:
www.anzics.com.au/files/brain_death_organ_donation.pdf at
www.anzics.com.au/contact.htm
Accessed 8 May, 2007

⁶ Salerno, Steve. ***The Heart-Stopping Truth about Organ Donation***. Playboy Magazine, October 2002. Chicago Illinois, USA.

⁷ Woodcock, Tom. ***Evidence-based versus "established" medical practice***. *British Medical Journal*, 2002 *BMJ* 2002;324:1099 (4 May) 2002
http://www.bmj.com/cgi/content/full/324/7345/1099?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&author1=woodcock%25252C+tom&andorexactitle=and&andorexactitleabs=and&andorexactfulltext=and&searchid=1074826141219_18798&stored_search=&FIRSTINDEX=0&sortspec=relevance&fdate=1/1/2002&tdate=12/31/2002&resourceype=1,2,3,4
Accessed 8 May, 2007

David J Hill, *retired anaesthetist* from the United Kingdom, agrees with Tom Woodcock.
<http://www.bmj.com/cgi/eletters/325/7368/836>

Accessed 8 May, 2007

⁸ Morioka, Masahiro. **Reconsidering Brain Death: A Lesson from Japan's Fifteen Years of Experience.** Hastings Center Report 31, no.4 (2001): 41-46
<http://www.lifestudies.org/reconsidering.html>
Accessed 8 May, 2007

⁹ **Guardian Newspaper**, United Kingdom. Sarah Boseley, Health Correspondent. 19 August 2000 www.guardianunlimited.co.uk

¹⁰ **Guardian Newspaper**, United Kingdom. Sarah Boseley, Health Correspondent. 19 August 2000 www.guardianunlimited.co.uk

¹¹ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death.** Kluwer Academic Publications, London, United Kingdom. 2000

¹² Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death.** Kluwer Academic Publications, London, United Kingdom. 2000

¹³ Machado, Nora, **Using the Bodies of the Dead**, Dartmouth Publishers, England, 1997. Dr Machado is quoting from Veatch:1993:18. Veatch, R. *The Impending Collapse of the Whole Brain Definition of Death.* Hastings Centre Report 1993a p 18-24.

¹⁴ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death.** Kluwer Academic Publications, London, United Kingdom. 2000

¹⁵ Professor Shewmon spoke on "**All In the Mind**", Radio National, Australian Broadcasting Corporation.
www.abc.net.au/rn/science/mind/s746719.htm
Accessed 8 May 2007

¹⁶ **David Wainwright Evans**, former cardiologist at Papworth Hospital, Cambridgeshire, United Kingdom. Personal correspondence to the author.

¹⁷ **David Hill, Dr David J. Hill** MA FRCA (Emeritus consultant anaesthetist) of Cambridgeshire, United Kingdom. Personal correspondence to the author.

¹⁸ Watanabe, Yoshio. **"Why do I stand against the movement for cardiac transplantation in Japan"**. from the Cardiovascular Institute, Fujita Health University School of Medicine. Toyoake, Japan July 21, 1994

Dr Watanabe recommends the following for further reference;

*Dowie, M. **We Have A Donor.** A Bold New World of Organ Transplanting, Japanese translation by M. Hirasawa, Heibon-sha, Tokyo 1990*

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

¹⁹ Young & Matta Editorial. **Anaesthesia** 2000;55;105-6 Correspondence Anaesthesia 2000 55;695-6

²⁰ Coimbra CG (1999) **Implications of ischaemic penumbra for the diagnosis of brain death**. Brazilian J Med Biol Res; 32:1538-1545 Study available at <http://www.unifesp.br/dneuro/brdeath.html>
Accessed 8 May 2007

²¹ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death**. Kluwer Academic Publications, London, United Kingdom. 2000
<http://www.springer.com/east/home?SGWID=5-102-0-0-0&referer=www.wkap.nl>
Accessed 8 May 2007

²² The author thanks **Dr David J. Hill** MA FRCA (Emeritus consultant anaesthetist) of Cambridgeshire, England, U.K. for help in interpretation.

²³ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death**. Kluwer Academic Publications, London, United Kingdom. 2000

²⁴ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death**. Kluwer Academic Publications, London, United Kingdom. 2000

²⁵ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death**. Kluwer Academic Publications, London, United Kingdom. 2000

²⁶ **Dr David Wainwright Evans**, former cardiologist at Papworth Hospital, Cambridgeshire, United Kingdom. Personal correspondence to the author.

²⁷ Schaller, C and Kessler, M. **On the difficulty of neurosurgical end of life decisions**. Department of Neurosurgery, University of Bonn Medical Centre, Bonn, Germany. (J Med Ethics 2006;32:65-69)
<http://jme.bmjournals.com/cgi/content/abstrac/32/2/65>
Accessed 8 May 2007

²⁸ **Dr David Wainwright Evans**, former cardiologist at Papworth Hospital, Cambridgeshire, United Kingdom. Personal correspondence to the author.

²⁹ **Dr David Wainwright Evans**, former cardiologist at Papworth Hospital, Cambridgeshire, United Kingdom. *Personal correspondence to the author.*

³⁰ **Coimbra, Cicero G**. British Medical Journal BMJ 2002;325:836
<http://bmj.com/cgi/eletters/325/7368/836#26574>
Accessed 29 April 2007

³¹ Watanabe, Yoshio. **"Why do I stand against the movement for cardiac transplantation in Japan"**. from the Cardiovascular Institute, Fujita Health University School of Medicine. Toyoake, Japan. July 21, 1994

³² Finn, Robert. **Organ Transplants**. O'Reilly and Associates Publishers, Sebastopol, California USA 2000

³³ Cooper, D.K.C. and Lanza, R.P. **Xeno**. Oxford University Press, New York, NY 2000 p 108

³⁴ Cooper, D.K.C. and Lanza, R.P. **Xeno**. Oxford University Press, New York, NY 2000

³⁵ Barnard, Christiaan and Curtis Bill Pepper. **One Life**. Australasian Publishing Company, Sydney, Australia 1972

³⁶ Clendinnen, Inga; **Tiger's Eye – A Memoir**, The Text Publishing Company, Melbourne, Australia, 2000 p281

³⁷ Clendinnen, Inga; **Tiger's Eye – A Memoir**, The Text Publishing Company, Melbourne, Australia, 2000 p286

³⁸ Cooper, D.K.C. and Lanza, R.P. **Xeno**. Oxford University Press, New York, NY 2000 page 178

³⁹ Black, Sir Douglas et al, **A Code of Practice for the Diagnosis of Brain Stem Death** – including guidelines for the identification and management of potential organ and tissue donors. Department of Health, United Kingdom. March 1998
http://www.uktransplant.org.uk/ukt/how_to_become_a_donor/questions/answers/further_info/brain_stem/code_of_practice.jsp?campaign=860
Accessed 29 April 2007

⁴⁰ Black, Sir Douglas et al, **A Code of Practice for the Diagnosis of Brain Stem Death** – including guidelines for the identification and management of potential organ and tissue donors. Department of Health, United Kingdom. March 1998
http://www.uktransplant.org.uk/ukt/how_to_become_a_donor/questions/answers/further_info/brain_stem/code_of_practice.jsp?campaign=860
Accessed 29 April 2007

⁴¹ Sanchez-Fructuoso A I, Marques M, Prats D, et al. **Victims of cardiac arrest occurring outside the hospital : a source of transplantable kidneys** (Ann Int Med 2006;145:157-164).
<http://www.annals.org/cgi/content/abstract/145/3/157>
Accessed 29 April 2007

⁴² **Dr David Filby**. Executive Director, Policy and Intergovernment Relations, Department of Health, South Australian Government. Personal correspondence with the author. 1 November 2006

⁴³ **Donation after Cardiocirculatory Death: A Canadian Forum. Report and Recommendations**. The Canadian Council for Donation and Transplantation. Sam D Shemie, Chair. Vancouver, Canada. 2005
<http://www.ccdt.ca/>
<http://www.ccdt.ca/english/publications/final.html#dcd>
Accessed 30 April 2007

⁴⁴ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death**. Kluwer Academic Publications, London, United Kingdom. 2000

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- ⁴⁵ **Australia New Zealand Organ Donor Registry (ANZOD)** Annual Report, editors Karen Herbertt and Graham Russ, ANZDATA Registry, Queen Elizabeth Hospital, Woodville, South Australia
<http://www.anzdata.org.au>
Accessed 30 April 2007
- ⁴⁶ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. ***Beyond Brain Death***. Kluwer Academic Publications, London, United Kingdom. 2000
- ⁴⁷ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. ***Beyond Brain Death***. Kluwer Academic Publications, London, United Kingdom. 2000
- ⁴⁸ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. ***Beyond Brain Death***. Kluwer Academic Publications, London, United Kingdom. 2000
- ⁴⁹ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. ***Beyond Brain Death***. Kluwer Academic Publications, London, United Kingdom. 2000
- ⁵⁰ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. ***Beyond Brain Death***. Kluwer Academic Publications, London, United Kingdom. 2000
- ⁵¹ **Adelaide Advertiser Newspaper**, Adelaide, Australia. 29-30 March 2001
- ⁵² **Australia and New Zealand Cardiothoracic Organ Transplant Registry 2005 REPORT**. Professor Anne Keogh and Ross Pettersson, Editors. ANZCOTR, C/- Level 5 DeLacy Building, ST Vincent's Hospital, Victoria Street, Darlinghurst, NSW 2010. p 19, 46
<http://www.anzcotr.org.au/>
Accessed 30 April 2007
- ⁵³ Cheney, Annie. ***Body Brokers: inside the underground trade in human remains***. Broadway Books, New York, U.S.A. 2006 p 189
http://www.randomhouse.com/broadway/catalog/results.pperl?title_auth_isbn=annie+chene&x=12&y=9
Accessed 30 April 2007
- ⁵⁴ Personal correspondence with the author. The writer has not given permission for her name to be printed.
- ⁵⁵ Goodwin, Michele. ***Black Markets: The supply and demand of body parts***. Cambridge University Press, New York, U.S.A. 2006 p58, 64-74
<http://www.cambridge.org/catalogue/catalogue.asp?isbn=0521852803>
Accessed 30 April 2007
- In *McFall v. Shimp* Robert McFall, 39, went to the courts because he wanted bone marrow from his cousin, David Shimp, Shimp won and kept his bone marrow.
- In *Curran v. Bosze* non-custodial parent Tamas Bosze wanted bone marrow from his twin daughters for their 12-year-old half brother.
- In *Strunk v. Strunk* a court decided a 27-year-old man with an IQ of 35 and ward of the state must give a kidney to his 28-year-old brother.

In Hart v. Brown the court decided to allow kidney to be removed from a seven-year-old girl and put into her twin sister.

All four cases were before courts in the United States of America.

⁵⁶ Matas, David; Kilgour, David. Report into allegations of organ harvesting of Falun Gong practitioners in China. 6 July 2006
Download their report as a pdf file
<http://davidkilgour.ca>
<http://organharvestinvestigation.net>
<http://investigation.go.saveinter.net>
Accessed 30 April 2007

⁵⁷ ***Kidney Donation by Live Donors.*** New South Wales Department of Health, 73 Miller Street, North Sydney. Australia. 2004 page 4
www.health.nsw.gov.au
Accessed 30 April 2007

What struck me with this guidebook for living kidney donors was the sentence: "Remember that is your decision...It's OK to say NO!" Why would potential donors need to be told this when they had decided to donate a kidney? The only reason I could think of was that the "donor" had been approached for a donation and not volunteered an organ.

⁵⁸ ***Donation after Cardiocirculatory Death: A Canadian Forum. Report and Recommendations.*** The Canadian Council for Donation and Transplantation. Sam D Shemie, Chair. Vancouver, Canada. 2005
<http://www.ccdt.ca/>
Accessed 30 April 2007

⁵⁹ *Brook, N.R. and Nicholson, M.L. Kidney transplantation from non heart-beating donors.* The University Division of Transplant Surgery, Leicester General Hospital, Gwendolen Road, Leicester, LE1 6GF
http://www.rcsed.ac.uk/journal/svol1_6/10600001.html
Accessed 30 April 2007

⁶⁰ ***Retrieving organs from non-heart-beating organ donors: a review of medical and ethical issues.*** Doig, Christopher James and Rocker, Graeme. *Canadian Journal of Anesthesia* 50:1069-1076 (2003)
<http://www.cja-jca.org/cgi/content/abstract/50/10/1069>
<http://www.cja-jca.org/cgi/content/full/50/10/1069>
Accessed 30 April 2007

⁶¹ Salerno, Steve. ***The Heart-Stopping Truth About Organ Donation.*** Playboy Magazine. Chicago Illinois, USA. October 2002
<http://www.geocities.com/organtransplanting/SalernoHeartArticle.html>
Accessed 30 April 2007

⁶² *Brook, N.R. and Nicholson, M.L. Kidney transplantation from non heart-beating donors.* The University Division of Transplant Surgery, Leicester General Hospital, Gwendolen Road, Leicester, LE1 6GF
http://www.rcsed.ac.uk/journal/svol1_6/10600001.html
Accessed 30 April 2007

⁶³ **David Wainwright Evans**, former cardiologist at Papworth Hospital, Cambridgeshire, United Kingdom. Personal correspondence to the author.

"Donation after cardiac death" has nothing to do with "brain death" and there is no pretence by the harvesters that they await "brain death" before beginning surgery. They don't confine their search for donors to those who might become candidates on those criteria. Anyone who is expected to die when life-support - meaning mechanical ventilation - is discontinued is a potential candidate, whatever the reason for ventilator-dependence. The transplanters rest their case for protection from charges of surgical assault on the unsupportable notion that waiting for 2 - 10 minutes after the last heartbeat ensures that the body/person is "really" dead - in the old-fashioned, traditional sense of the term. Bad science and sophistry again!"

⁶⁴ Hepatitis C: An Update. **Australian Family Physician**. Volume 32, Number 10. October 2003. p 48
<http://www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/HepatitisC/20031029hepc.pdf>
Accessed 30 April 2007

If link is inactive go to <http://www.racgp.org.au/guidelines/hepatitisc> then click on [Hepatitis C Guidelines 2003 Update \(889Kb\)](#)

⁶⁵ **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**
Accessed 30 April 2007

⁶⁶ **Deng, Mario, C.** BBC interview.
<http://news.bbc.co.uk/2/hi/health/904627.stm>
Accessed 30 April 2007

⁶⁷ **Intrathoracic organ transplantation in the United Kingdom 1995-99: results from the UK cardiothoracic transplant audit.**
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11997419&dopt=Abstract
Accessed 30 April 2007

The report Abstract concludes that: "This validated database defines the current state of thoracic transplantation in the United Kingdom and is a useful source of data for workers involved in the field. 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."

⁶⁸ **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."

⁶⁹ Personal Correspondence with the author. The doctor was speaking privately and off the record.

⁷⁰ National Marrow Donor Program (U.S.A.)
http://www.marrow.org/PATIENT/understanding_survival_statistics.html
Accessed 1 May 2007

⁷¹ **Orange County Register Newspaper**, California. U.S.A. Body Broker Series. April 16-20, 2000.
www.oregister.com/features/body/index.shtml
Accessed 1 May 2007

⁷² **Orange County Register Newspaper**, California. U.S.A. Body Broker Series. April 16-20, 2000.
www.oregister.com/features/body/index.shtml
Accessed 1 May 2007

⁷³ **The Pharmacy Guild of Australia** logo appears twice on the Australian government's 2007 Organ Donor Register consent card and promotion material. Next to one logo the following words appear: "*Proudly supported by The Pharmacy Guild of Australia*".

Glaxo-Wellcome (now known as Glaxo-Smith-Kline) has funded the Victorian Donor Registry in Australia with \$400,000.

Fujisawa, who manufacture 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 Tacrolimus (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)

⁷⁴ **Orange County Register Newspaper**, California. U.S.A. *Body Broker Series*. 16-20 April, 2000.

www.ocregister.com/features/body/index.shtml

Accessed 1 May 2007

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?

⁷⁵ **Orange County Register Newspaper**, California. U.S.A. *Body Broker Series*. 16-20 April, 2000.

www.ocregister.com/features/body/index.shtml

Accessed 1 May 2007

⁷⁶ **Orange County Register Newspaper**, California. U.S.A. *Body Broker Series*. 16-20 April, 2000. www.ocregister.com/features/body/index.shtml

Accessed 1 May 2007

⁷⁷ Cheney, Annie. **Body Brokers: inside the underground trade in human remains**. Broadway Books, New York, U.S.A. 2006 p 189

http://www.randomhouse.com/broadway/catalog/results.pperl?title_auth_isbn=annie+cheneey&x=12&y=9

Accessed 1 May 2007

⁷⁸ **Orange County Register Newspaper**, California. U.S.A. *Body Broker Series*. 16-20 April, 2000. www.ocregister.com/features/body/index.shtml

Accessed 1 May 2007

⁷⁹ **Grasby, Dallas**. Tissue Bank of South Australia. Frome Road, Adelaide. Personal communication with the author. August 2006

⁸⁰ **Adelaide Advertiser Newspaper**, Adelaide, South Australia, Australia. 7 January, 2002

⁸¹ **Vowles, Damon**. Personal communication with the author.

⁸² **Bell, Sir Peter**. Professor of Surgery at the University of Leicester, **Plan to offer cash to organ donors**, Guardian Weekly, London, United Kingdom. October 24-30, 2002

⁸³ **Tonti-Filippini, Nicholas**. *Revising Brain Death: Cultural Imperialism*, Linacre Quarterly. Boston. May 1998

⁸⁴ **Kidney Donation by Live Donors.** New South Wales Department of Health, 73 Miller Street, North Sydney. Australia. 2004 page 4 www.health.nsw.gov.au

⁸⁵ Veatch, Robert M. **Why Liberals Should Accept Financial Incentives for Organ Procurement** Kennedy Institute of Ethics Journal Vol. 13, No. 1, 19–36 © 2003 The Johns Hopkins University Press

⁸⁶ http://www.knesset.gov.il/library/eng/docs/sif032_eng.htm
Accessed 1 May 2007

⁸⁷ **Evans, David W.** Retired physician, *Queens' College, Cambridge, CB3 9E*
<http://bmj.bmjournals.com/cgi/eletters/333/7571/746?ehom#144121>
Accessed 1 May 2007

⁸⁸ **Chadban, Steve. Manager,** ANZDATA Transplant Section. Steve was writing in the **ANZOD Registry Report 2005** Australia and New Zealand Organ Donation Registry. Adelaide, South Australia.
Editors: Leonie Excell, Graeme Russ, Penny Wride
<http://www.anzdata.org.au>
<http://www.anzdata.org.au/ANZOD/ANZODReport/anzodreport.htm#2006>
Accessed 1 May 2007

⁸⁹ Tonti-Filippini, Nicholas. **Revising Brain Death: Cultural Imperialism,** Linacre Quarterly. Boston. May 1998

Nicholas served as health care ethicist for eight years at St Vincent's Hospital, Melbourne, Australia

⁹⁰ <http://www.alicespringsnews.com.au/0539.html>
Accessed 1 May 2007

⁹¹ <http://www.drs.org.au/wwwboard/messages/169.html>
Accessed 1 May 2007

⁹²
<http://www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/HepatitisC/20031029hepc.pdf>
Accessed 3 May 2007

If link is inactive go to <http://www.racgp.org.au/guidelines/hepatitisc> then click on [Hepatitis C Guidelines 2003 Update \(889Kb\)](#)

⁹³ **Deng, Mario,** C. BBC interview.
<http://news.bbc.co.uk/2/hi/health/904627.stm>
Accessed 3 May 2007

⁹⁴ **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: www.bmj.com/cgi/content/full/321/7260/540
Accessed 3 May 2007

⁹⁵ **Edmond, Wendy** <http://www.hepatitisforeningen.dk/enyheder.asp?id=139&aktion=vis>
Accessed 3 May 2007

⁹⁶ *Time Magazine* (Australian Edition), **Life Out Of Death** by Leora Moldofsky. Sydney, Australia. 26 February 2001

⁹⁷ Bendle, Stephen, National Manager, Australians Donate Inc, www.australiansdonate.org.au Email exchanges with the author.

⁹⁸ Bendle, Stephen, National Manager, Australians Donate Inc, www.australiansdonate.org.au Email exchanges with the author.

⁹⁹ Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death**. Kluwer Academic Publications, London, United Kingdom. 2000

¹⁰⁰ Tonti-Filippini, Nicholas. **Revising Brain Death: Cultural Imperialism**, Linacre Quarterly. Boston. May 1998

The author served as health care ethicist for eight years at St Vincent's Hospital, Melbourne, Australia

¹⁰¹ <http://www.geocities.com/organdonate>
Accessed 3 May 2007

¹⁰² <http://www.jotnw.or.jp>
Accessed 3 May 2007

¹⁰³ **OrganKeeper™** is a Trademark name owned by Duane Horton of Rhode Island, U.S.A. who operates www.organkeeper.com
Accessed 3 May 2007

¹⁰⁴ www.organkeeper.com
Accessed 3 May 2007

¹⁰⁵ 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 still laughing.

¹⁰⁶ Letter from Brendan Gibson from the Department of Health and Ageing, Australian Government. 27 February, 2007. File Reference:2006/023548

¹⁰⁷ *Time Magazine* (Australian Edition), Sydney, Australia. 26 February 2001

¹⁰⁸ Scheper-Hughes, Nancy; **Organ Watch** at the University of California, Berkeley <http://sunsite.berkeley.edu/biotech/organswatch/>
Accessed 3 May 2007

¹⁰⁹ The American states using presumed consent are California, Florida, Hawaii, Kentucky, Louisiana, Maryland, Michigan, North Carolina and Wisconsin.

Goodwin, Michele. **Black Markets: The supply and demand of body parts**. Cambridge University Press, New York, U.S.A. 2006 p 125
<http://www.cambridge.org/catalogue/catalogue.asp?isbn=0521852803>
Accessed 3 May 2007

- ¹¹⁰ *Death, dying and donation: organ transplantation and the diagnosis of death.* I H Kerridge, P Saul, M Lowe, J McPhee and D Williams. *Journal of Medical Ethics. J Med Ethics* 2002;**28**:89-94
<http://jme.bmj.com/cgi/content/full/28/2/89>
Accessed 3 May 2007
- ¹¹¹ Tonti-Filippini, Nicholas. ***Revising Brain Death: Cultural Imperialism***, Linacre Quarterly. Boston. May 1998
- ¹¹² ***ANZOD Registry Report 2005***, Australia and New Zealand Organ Donation Registry. Adelaide, South Australia.
Editors: Leonie Excell, Graeme Russ, Penny Wride
<http://www.anzdata.org.au>
<http://www.anzdata.org.au/ANZOD/ANZODReport/anzodreport.htm#2006>
Accessed 3 May 2007
- ¹¹³ 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
Accessed 3 May 2007
- ¹¹⁴ **Evans, David W.** "Living organ donation". *British Medical Journal Rapid Responses.* <http://bmj.bmjournals.com/cgi/eletters/333/7571/746?ehom#144121>
Accessed 3 May 2007
- ¹¹⁵ ***Organ Transplants From Living Donors (Kidneys) - Israel 2003***
Ronit Kedem-Dror
http://www.knesset.gov.il/library/eng/docs/sif032_eng.htm
Accessed 3 May 2007
- ¹¹⁶ Finn, Robert. ***Organ Transplants.*** O'Reilly and Associates Publishers, Sebastopol, California USA 2000 p90
- ¹¹⁷ Dowie, Mark; ***We Have A Donor***, St Martin's Press, 175 Fifth Avenue New York. P116
- ¹¹⁸ Clendinnen, Inga; ***Tiger's Eye – A Memoir***, The Text Publishing Company, Melbourne, Australia, 2000
- ¹¹⁹ Watanabe, Yoshio. ***"Why do I stand against the movement for cardiac transplantation in Japan"?*** from the Cardiovascular Institute, Fujita Health University School of Medicine. Toyoake, Japan July 21, 1994
- ¹²⁰ Clendinnen, Inga; ***Tiger's Eye – A Memoir***, The Text Publishing Company, Melbourne, Australia, 2000
- ¹²¹ Matas, David; Kilgour, David. Report into allegations of organ harvesting of Falun Gong practitioners in China. 6 July 2006
Download their report as a pdf file
<http://davidkilgour.ca>
<http://organharvestinvestigation.net>
<http://investigation.go.saveinter.net>
Accessed 4 May 2007

¹²² **Organ Transplants from Living Donors (Kidneys) - Israel 2003**

Ronit Kedem-Dror

http://www.knesset.gov.il/library/eng/docs/sif032_eng.htm

Accessed 4 May 2007

¹²³ Personal correspondence with the author. **Dr Robert Claxton** was asked by the Sydney Diocese Secretariat of the Anglican Church to respond to questions put to them.

¹²⁴ **His Holiness Pope John Paul II**, in his address to the International Conference of the Transplantation Society on 29 August, 2000. The full transcript of the Pope's address is at:

http://www.vatican.va/holy_father/john_paul_ii/speeches/2000/jul-sep/documents/hf_jp-ii_spe_20000829_transplants_en.html

Accessed 4 May 2007

¹²⁵ **Queensland Right To Life**, Personal Correspondence with the author.

¹²⁶ **His Holiness Pope John Paul II**, in his address to the International Conference of the Transplantation Society on 29 August, 2000. The full transcript of the Pope's address is at:

http://www.vatican.va/holy_father/john_paul_ii/speeches/2000/jul-sep/documents/hf_jp-ii_spe_20000829_transplants_en.html

Accessed 4 May 2007

¹²⁷ **Transfusion Alternatives**. 2004. Watch Tower Bible and Tract Society of New York, 25 Columbia Heights, New York, United States. 2004

¹²⁸ Chang, Garma C.C.; **The Six Yogas of Naropa and Teaching on Mahamudra**, Snow Lion Publications, New York, USA

¹²⁹ Matas, David; Kilgour, David. Report into allegations of organ harvesting of Falun Gong practitioners in China. 6 July 2006

Download their report as a pdf file

<http://davidkilgour.ca>

<http://organharvestinvestigation.net>

<http://investigation.go.saveinter.net>

Accessed 4 May 2007

¹³⁰ Scheper-Hughes, Nancy; **Organ Watch** at the University of California, Berkeley

<http://sunsite.berkeley.edu/biotech/organswatch/>

Accessed 22 February 2007

¹³¹ Matas, David; Kilgour, David. **Report into allegations of organ harvesting of Falun Gong practitioners in China**. 6 July 2006

Download their report as a pdf file

<http://davidkilgour.ca>

<http://organharvestinvestigation.net>

<http://investigation.go.saveinter.net>

Accessed 4 May 2007

¹³² South Australian Organ Donation Agency, **Legal and Ethical Aspects**, circa 1995, Adelaide South Australia

¹³³ **Japan Organ Transplant Network.**

<http://www.jotnw.or.jp/english/index.html>

Accessed 4 May 2007

¹³⁴ South Australian Organ Donation Agency, **Legal and Ethical Aspects**, circa 1995, Adelaide South Australia

¹³⁵ Personal communication to the author from **Janine Werneberg** of the Church of Scientology in Australia

¹³⁶ Goodwin, Michele. **Black Markets: The supply and demand of body parts.**

Cambridge University Press, New York, U.S.A. 2006 p132-133

<http://www.cambridge.org/catalogue/catalogue.asp?isbn=0521852803>

¹³⁷ **Australia New Zealand Organ Donor (ANZOD) Annual Reports**, editors Karen Herbertt and Graham Russ, ANZDATA Registry, Queen Elizabeth Hospital, Woodville, South Australia

There site contains ANZOD Annual Reports from 1997 to present.

<http://www.anzdata.org.au>

<http://www.anzdata.org.au/ANZOD/ANZODReport/anzodreport.htm#2006>

Accessed 4 May 2007

¹³⁸ **Australia New Zealand Organ Donor (ANZOD) Annual Reports**, editors Karen Herbertt and Graham Russ, ANZDATA Registry, Queen Elizabeth Hospital, Woodville, South Australia

There site contains ANZOD Annual Reports from 1997 to present.

<http://www.anzdata.org.au>

<http://www.anzdata.org.au/ANZOD/ANZODReport/anzodreport.htm#2006>

Accessed 4 May 2007

¹³⁹ 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:

www.bmj.com/cgi/content/full/321/7260/540

Accessed 4 May 2007

¹⁴⁰ Anyanwu AC, Rogers CA, Murday AJ; Steering Group. **Intrathoracic organ transplantation in the United Kingdom 1995-99: results from the UK cardiothoracic transplant audit.**

The UK Cardiothoracic Transplant Audit, Clinical Effectiveness Unit, The Royal College of Surgeons of England, London, UK.

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11997419&dopt=Abstract

Accessed 4 May 2007

¹⁴¹ **Australia and New Zealand Cardiothoracic Organ Transplant Registry 2005 REPORT.** Professor Anne Keogh and Ross Pettersson, Editors. ANZCOTR, C/- Level 5 DeLacy Building, ST Vincent's Hospital, Victoria Street, Darlinghurst, NSW 2010

<http://www.anzcotr.org.au/>

Accessed 4 May 2007

¹⁴² 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 (2September,2000), Available at British Medical Journal web site at www.bmj.com/cgi/content/full/321/7260/540
Accessed 4 May 2007

¹⁴³ Cooper, D.K.C. and Lanza, R.P. **Xeno**. Oxford University Press, New York, NY 2000
p 26

¹⁴⁴ Barnard, Christiaan and Curtis Bill Pepper. **One Life**. Australasian Publishing Company, Sydney, Australia 1972

¹⁴⁵ Cooper, D.K.C. and Lanza, R.P. **Xeno**. Oxford University Press, New York, NY 2000
p 32

¹⁴⁶ Cooper, D.K.C. and Lanza, R.P. **Xeno**. Oxford University Press, New York, NY 2000
p26

¹⁴⁷ Cooper, D.K.C. and Lanza, R.P. **Xeno**. Oxford University Press, New York, NY 2000
p24-25

¹⁴⁸ Cooper, D.K.C. and Lanza, R.P. **Xeno**. Oxford University Press, New York, NY 2000
p206

¹⁴⁹ Cooper, D.K.C. and Lanza, R.P. **Xeno**. Oxford University Press, New York, NY 2000.
p 34

¹⁵⁰ Cooper, D.K.C. and Lanza, R.P. **Xeno**. Oxford University Press, New York, NY 2000
p39-40

The authors say the last they heard about him was from The New Indian Express of February 2, 1999. He had gotten out of jail and announced his intention of performing further xenotransplants.

¹⁵¹ Brumm, Judith. **This Little Piggy Went to the Biotech Market**. Nursing Spectrum Magazine, United States.
<http://community.nursingspectrum.com/MagazineArticles/article.cfm?AID=8146>
Accessed 5 may 2007

¹⁵² Cooke, Jennifer, **Cannibals, Cows and the CJD Catastrophe**, Random House, Milsons Point, NSW 1998

¹⁵³ Allars, Margaret. **Inquiry into the use of Pituitary Derived Hormones in Australia and Creutzfeldt-Jakob Disease**, Australian Govt Publishing Services, Canberra, Australia. 1994. *This independent inquiry was funded by the government after public opinion and victims' relatives wouldn't accept the Australian government's own investigation. A more popular and readable version of hGH and CJD is found in Jennifer Cooke's **Cannibals, Cows and the CJD Catastrophe**.*

¹⁵⁴ Allars, Margaret. ***Inquiry into the use of Pituitary Derived Hormones in Australia and Creutzfeldt-Jakob Disease***, Australian Govt Publishing Services, Canberra, Australia. 1994

¹⁵⁵ Allars, Margaret. ***Inquiry into the use of Pituitary Derived Hormones in Australia and Creutzfeldt-Jakob Disease***, Australian Govt Publishing Services, Canberra, Australia. 1994. P 75-79

¹⁵⁶ Allars, Margaret. ***Inquiry into the use of Pituitary Derived Hormones in Australia and Creutzfeldt-Jakob Disease***, Australian Govt Publishing Services, Canberra, Australia. 1994. P71

¹⁵⁷ Allars, Margaret. ***Inquiry into the use of Pituitary Derived Hormones in Australia and Creutzfeldt-Jakob Disease***, Australian Govt Publishing Services, Canberra, Australia. 1994. P69

¹⁵⁸ Allars, Margaret. ***Inquiry into the use of Pituitary Derived Hormones in Australia and Creutzfeldt-Jakob Disease***, Australian Govt Publishing Services, Canberra, Australia. 1994. P 392,393,396

¹⁵⁹ Allars, Margaret. ***Inquiry into the use of Pituitary Derived Hormones in Australia and Creutzfeldt-Jakob Disease***, Australian Govt Publishing Services, Canberra, Australia. 1994. P391

¹⁶⁰ Allars, Margaret. ***Inquiry into the use of Pituitary Derived Hormones in Australia and Creutzfeldt-Jakob Disease***, Australian Govt Publishing Services, Canberra, Australia. 1994

¹⁶¹ Allars, Margaret. ***Inquiry into the use of Pituitary Derived Hormones in Australia and Creutzfeldt-Jakob Disease***, Australian Govt Publishing Services, Canberra, Australia. 1994.

¹⁶² Cooke, Jennifer, ***Cannibals, Cows and the CJD Catastrophe***, Random House, Milsons Point, NSW 1998

¹⁶³ Scheper-Hughes, Nancy; ***Organ Watch*** at the University of California, Berkeley
<http://sunsite.berkeley.edu/biotech/organswatch/>
Accessed 5 May 2007

¹⁶⁴ Goodwin, Michele. ***Black Markets: The supply and demand of body parts***. Cambridge University Press, New York, U.S.A. 2006 p58, 64-74
<http://www.cambridge.org/catalogue/catalogue.asp?isbn=0521852803>
Accessed 5 May 2007

¹⁶⁵ British Medical Journal. ***Police uncover large scale organ trafficking in Punjab***, Sanjay Kumar, New Delhi. *BMJ* 2003;326:180 (25 January)
http://www.bmj.com/cgi/content/full/326/7382/180/b?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=india+police+organ+trade&searchid=1044231481110_13838&stored_search=&FIRSTINDEX=0&volume=326&issue=7382
Accessed 5 May 2007

¹⁶⁶ Cheney, Annie. ***Body Brokers: inside the underground trade in human remains***. Broadway Books, New York, U.S.A. 2006 p 189

http://www.randomhouse.com/broadway/catalog/results.pperl?title_auth_isbn=annie+chene&x=12&y=9

Accessed 5 May 2007

¹⁶⁷ Telegraph Newspaper, United Kingdom 23 December 2005.

www.telegraph.co.uk

¹⁶⁸ Goodwin, Michele. **Black Markets: The supply and demand of body parts.** Cambridge University Press, New York, U.S.A. 2006 p117-119

<http://www.cambridge.org/catalogue/catalogue.asp?isbn=0521852803>

Accessed 5 May 2007

¹⁶⁹ Goodwin, Michele. **Black Markets: The supply and demand of body parts.**

Cambridge University Press, New York, U.S.A. 2006 p 125

<http://www.cambridge.org/catalogue/catalogue.asp?isbn=0521852803>

Accessed 5 May 2007

¹⁷⁰ Campbell, Ronald, Heisel, William and Katches, Mark. **Orange County Register Newspaper, California. U.S.A. Body Broker Series. April 16-20, 2000.**

www.ocregister.com/features/body/index.shtml

Accessed 5 May 2007

¹⁷¹ Campbell, Ronald, Heisel, William and Katches, Mark. **Orange County Register Newspaper, California. U.S.A. Body Broker Series. April 16-20, 2000.**

www.ocregister.com/features/body/index.shtml

Accessed 5 May 2007

¹⁷² Cheney, Annie. **Body Brokers: inside the underground trade in human remains.** Broadway Books, New York, U.S.A. 2006 p 149-153

http://www.randomhouse.com/broadway/catalog/results.pperl?title_auth_isbn=annie+chene&x=12&y=9

Accessed 5 May 2007

¹⁷³ Cheney, Annie. **Body Brokers: inside the underground trade in human remains.** Broadway Books, New York, U.S.A. 2006 p 146

http://www.randomhouse.com/broadway/catalog/results.pperl?title_auth_isbn=annie+chene&x=12&y=9

Accessed 5 May 2007

¹⁷⁴ Matas, David; Kilgour, David. **Report into allegations of organ harvesting of Falun Gong practitioners in China.** 6 July 2006

Download their report as a pdf file

<http://davidkilgour.ca>

<http://organharvestinvestigation.net>

<http://investigation.go.saveinter.net>

Accessed 8 May 2007

¹⁷⁵ <http://sunsite.berkeley.edu/biotech/organswatch/pages/cannibalism.html>

Accessed 8 May 2007

For a precise history of the organ trade see **The Global Traffic in Human Organs** by Professor Nancy Scheper-Hughes at:

<http://72.14.235.104/search?q=cache:ls0qw5NpvmsJ:pascalfroissart.online.fr/3-cache/2000-scheperhughes.pdf+%22doctor+who+routinely+participated+in+removing+kidneys+%22&hl=en&gl=au&ct=clnk&cd=4>

Accessed 8 May 2007

¹⁷⁶ Matas, David; Kilgour, David. Report into allegations of organ harvesting of Falun Gong practitioners in China. 6 July 2006

Download their report as a pdf file

<http://davidkilgour.ca>

<http://organharvestinvestigation.net>

<http://investigation.go.saveinter.net>

Accessed 8 May 2007

¹⁷⁷ Dr David Filby. Executive Director, Policy and Intergovernment Relations, Department of Health, South Australian Government. Personal correspondence with the author. 1 November 2006

¹⁷⁸ *Allars, Margaret. Inquiry into the use of Pituitary Derived Hormones in Australia and Creutzfeldt-Jakob Disease, Australian Govt Publishing Services, Canberra, Australia. 1994.*

¹⁷⁹ *Healey, Kaye, Editor, Organ Transplants, Spinney Press, Balmain, New South Wales, Australia. 1996*

¹⁸⁰ Australian Broadcasting Corporation

<http://abc.net.au/news/newsitems/200608/s1718577.htm>

Friday, August 18, 2006. 3:48pm (AEST)

Accessed 8 May 2007

¹⁸¹ The Adelaide Advertiser. Adelaide, South Australia. 7 February 2007. p 25

www.news.com.au/adelaidenow

¹⁸² Ahmad, Rasheed MB; MSc; FRCP.

Emeritus Consultant Nephrologist

'Shalamar', Woolton Park, Liverpool L25 6DU

<http://bmj.bmjournals.com/cgi/eletters/333/7571/746?ehom#144121>

Accessed 8 May 2007

¹⁸³ Goodwin, Michele. ***Black Markets: The supply and demand of body parts.***

Cambridge University Press, New York, U.S.A. 2006 p188

<http://www.cambridge.org/catalogue/catalogue.asp?isbn=0521852803>

Accessed 8 May 2007

¹⁸⁴ Goodwin, Michele. ***Black Markets: The supply and demand of body parts.***

Cambridge University Press, New York, U.S.A. 2006 p187-189

<http://www.cambridge.org/catalogue/catalogue.asp?isbn=0521852803>

Accessed 8 May 2007

¹⁸⁵ *Scheper-Hughes, Nancy; Organ Watch at the University of California, Berkeley*

<http://sunsite.berkeley.edu/biotech/organswatch>

Accessed 8 May 2007

La Stampa,

26 November, 1993.

STATEMENT OF Professor NANCY SCHEPER-HUGHES,
PROJECT DIRECTOR, ORGANS WATCH

from THE COMMITTEE ON INTERNATIONAL RELATIONS, HOUSE OF
REPRESENTATIVES, United States Congress

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WASHINGTON : 73452PS2001

ORGANS FOR SALE:

CHINA'S GROWING TRADE AND ULTIMATE VIOLATION OF PRISONERS' RIGHTS

HEARING BEFORE THE SUBCOMMITTEE ON INTERNATIONAL OPERATIONS AND HUMAN RIGHTS OF THE COMMITTEE ON INTERNATIONAL RELATIONS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SEVENTH CONGRESS
FIRST SESSION JUNE 27, 2001 Serial No. 1072

- ¹⁸⁶ **South African doctors charged with involvement in organ trade**
British Medical Journal.
BMJ 2004;329:190 (24 July), doi:10.1136/bmj.329.7459.190-a
<http://bmj.bmjournals.com/cgi/content/full/329/7459/190-a>
Accessed 8 May 2007
- ¹⁸⁷ **Hearts and Minds.** Christine Toomey. The Weekend Australian Magazine. Published by Nationwide News Pty Ltd. July 22-23 2006
- ¹⁸⁸ Yallop, David; **To the Ends of the Earth.** Jonathan Cape, London 1993 p286-288. 295-,297.
- ¹⁸⁹ Yallop, David; **To the Ends of the Earth.** Jonathan Cape, London 1993 p286-288. 295-297
- ¹⁹⁰ Yallop, David; **To the Ends of the Earth.** Jonathan Cape, London 1993 p286-288. 295-297
- ¹⁹¹ **Doctors charged with planning to kill a patient for his kidneys.** Andrew Osborn. British Medical Journal BMJ 2004;328:1092 (8 May), doi:10.1136/bmj.328.7448.1092-a
<http://bmj.bmjournals.com/cgi/content/full/328/7448/1092-a>
Accessed 8 May 2007
- ¹⁹² **GM Guiraudon personal communication with Cardiologist Yoshio Watanabe written in "Why do I stand against the movement for cardiac transplantation in Japan".** from the Cardiovascular Institute, Fujita Health University School of Medicine. Toyoake, Japan July 21, 1994
- ¹⁹³ Watanabe, Yoshio. **"Why do I stand against the movement for cardiac transplantation in Japan".** from the Cardiovascular Institute, Fujita Health University School of Medicine. Toyoake, Japan July 21, 1994
- ¹⁹⁴ **Cosmetic surgery special: When looks can kill.** New Scientist Magazine
19 October 2006
<http://www.newscientist.com/channel/health/mg19225745.200>
Accessed 8 May 2007
- Plastic surgery linked to more suicide: study.** CTV Network, Canada Oct. 8 2006
http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20061008/breast_implants_061008?s_name=&no_ads=
Accessed 8 May 2007
- ¹⁹⁵ Prasad, K.R. and Lodge, J.P.A.; **Transplantation of the Liver and Pancreas;** British Medical Journal, United Kingdom 7 April, 2001
- ¹⁹⁶ Hepatitis C: An Update. **Australian Family Physician.** Volume 32, Number 10. October 2003. p 48
<http://www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/HepatitisC/20031029hepc.pdf>
Accessed 8 May 2007

If link is inactive go to <http://www.racgp.org.au/guidelines/hepatitisc> then click on [Hepatitis C Guidelines 2003 Update \(889Kb\)](#)

¹⁹⁷ *Scheper-Hughes, Nancy; **Organ Watch** at the University of California, Berkeley*
<http://sunsite.berkeley.edu/biotech/organswatch/>
Accessed 8 May 2007

¹⁹⁸ Goodwin, Michele. **Black Markets: The supply and demand of body parts.**
Cambridge University Press, New York, U.S.A. 2006 p58, 64-74 See End Note 55 for
more details.
<http://www.cambridge.org/catalogue/catalogue.asp?isbn=0521852803>
Accessed 8 May 2007

¹⁹⁹ *Personal correspondence with the author. The writer has not given permission for her
name to be published.*

²⁰⁰ *Potts, Michael; Byrne, Paul A. and Nilgais, Richard, editors. **Beyond Brain Death.**
Kluwer Academic Publications, London, United Kingdom. 2000*

²⁰¹ *Potts, Michael; Byrne, Paul A. and Nilges, Richard, editors. **Beyond Brain Death.**
Kluwer Academic Publications, London, United Kingdom. 2000*

²⁰² *Barnard, Christiaan; **The Second Life: Memoirs,** Hodder and Stoughton, Sydney,
Australia 1993. P33*

²⁰³ *Scientists from the United Kingdom and Belgium have discovered a woman in a
persistent vegetative state who can understand and respond to verbal suggestions.*

<http://www.medicalnewstoday.com/healthnews.php?newsid=51473>

<http://www.sciencemag.org/cgi/content/abstract/313/5792/1402>

<http://www.melaniephillips.com/articles-new/?p=449>

Accessed 8 May 2007

²⁰⁴ *Cooper, D.K.C. and Lanza, R.P. **Xeno.** Oxford University Press, New York, NY 2000
p134,135*