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Ethics, Surgeons, & Transplantation

Decisions about how to practice medicine can be made in one of three ways:

1. We can assume that the problems are so complex that they must be left to the experts, that is, to scientists and their ethics counselors.

2. We can insist that these problems must be handled by the public, even though the public often lacks adequate technical knowledge or sufficient reflection on the ethical issues involved, because this is what our established values require.

3. We can strive to create an informed public that works with technical professionals and their ethics counselors to reach an informed consensus.

The first option is intelligent but undemocratic. The second is democratic but unintelligent. The third is an intelligent and democratic way that integrates cultures of expertise into a self-reflective public. Only this can set the stage for realizing the full promise of the applied ethics of technology. The public is always keenly interested in where surgery is going and the integrity of those who are taking us there. The unprecedented ability of scientists to manipulate life and death, to create altered biological processes, and to re-engineer biological systems as in transplantation has made fundamental changes in how we heal and how we relate to the living and to the dying world. The general public, however, and even health care professional are often wary of ethical scrutiny, and generally reluctant to engage in moral conversation about life and death. They are in a state of denial. Doctors prefer to leave the field to bioethicists and lay public to media. Both are manipulated and influenced by the transplant business people who include secular bioethicists, surgeons, anesthesiologists, transplant coordinators, nurses and people of the business.

The morality of organ procurement and harvesting is not longer questioned because of the powerful lobbying and deceitful marketing techniques being used to encourage the so-called donation of human organs. A worldwide billion-dollar industry has been created. Hospitals and medical universities receive prestige and big funding from transplant programs. No other surgical program can contribute to financial success provided obviously that there is a steady flow of organs from accidents.

Organ procurement and allocation decisions are full of ethical problems:

- consent to organ donation,
- excess demand of organs,
- compensation for donation,
- organ distribution,
- living donation,
- multiple standards of death,
- repeated transplant,
- use of flawed organs,

- baby harvesting,
- inverse age,
- executed donors,
- criminal recipients,
- tourist transplant.

However the crucial question is: is it ethical to excise a beating heart from a person who has all vital signs – a patient who is warm, has normal blood pressure and circulation, and has many other intact, functioning organs and systems maintaining the unity of the organism as a whole? The fact that the donor's body, if mechanically ventilated, is digesting and absorbing food, urinating, defecating, filtering blood through the kidneys and liver, healing itself when injured, maintaining body temperature and even keeping alive and growing a foetus in utero, means nothing to the explant-transplant industry. The patient is declared "brain dead", family is informed that the patient is legally dead and he is as soon as convenient classified as donor and operated upon. Nearly all physicians are unfamiliar with the utter brutality of this legal medical practice that can be compared to torture with subsequent execution. The public assumes that what seems questionable must be all right if the "experts" are doing it. They should know instead that what is ethically and morally wrong is always wrong, even if thousand of "experts" are approving and doing it and a myriad of people applauding and cheering as it was in the past with inquisition, guillotine, hangings and the likes.

Few physicians have been able to get their voices heard in media, congresses, and even in medical publications. The main journals are usually controlled by medical societies financed by Big Pharma and those who have been supporting "brain death" as true death. It is not surprising that most physician either ignore the procurement process for lacking of information or avoid the problem for fear of being considered too conservative, uninformed, or non-altruistic. Not a single investigation or action for "brain dead" donors while they await extraction of their organs is in the interest of the patient. Every step is done to keep alive the body and sometimes even to crash the brain as may happens in the so-called uncontrolled non-beating heart patients.

All began in the late sixties to avoid the legal and ethical problems physicians were persuaded to pronounce and to certify beating hearth patients "dead" before the procurement surgery commenced. The Harvard Medical School gave scientific power to the matter 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 decided that death could be proclaimed if a ventilator-dependent patient failed to respond to a series of reflex tests. 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. The Harvard Criteria established that a *prognosis* of death is equivalent to a *certification* of death. This new definition of death was a request of the transplant surgeons and a legal bonus 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. What for centuries was murder was the next day of Harvard declaration a brilliant surgical technique. Now different types of deaths equals the numbers of hospitals: what is death here is not death there.

The donor patient is given: intravenous fluids including refrigerants such as polyethilene glycole, blood transfusions, thyroid hormone, adrenal hormones. A paralysing drug is administered to stop the donor from moving during the extraction of organs since both anesthesiologists and nurses had become concerned when the supposed "cadaver," who is breathing with the assistance of a ventilator, would squirm and move as they clamp, tie and cut into the chest and abdomen to extract heart, lungs, liver, kidney, pancreas, and intestine.

When anesthetics are not used, the heart rate and blood pressure of the donor patient increase. The infusion of anesthetic removes this response. The truly dead patient cannot have any change in heart rate. Blood pressure does not occur in truly dead patients. The heart of a person about to be disemboweled beats at the same rate of a healthy person's heart and the rate increases as a response to the surgical manoeuvres.

Life of the body is prolonged, death is declared, a gruesome agony is artificially extended.

Many families sign for donation to obtain the illusion of a form of immortality for the dying, to became part of social body, to oblige the uninformed wishes of the dying, or social, medical, media influences. Numbing and guilty feelings are however responsible for surrendering to the manipulative questions of professional requestors. Transplant coordinators have quotas, punishments for insufficient procurements, and career and money according to the conversion rate.

Donor cards are offered to uninformed people attributing them the reward of altruism. These Death Lottery Tickets are the life insurance of the business of explant -transplant industry. No effort is made to define what constitutes death for the transplant business. People accept incuriously the card with a scandalous lack of understanding about the explant procedures, a reassuring reward of social acceptance but certainly with the secret hope not to win the jackpot: early declaration of death and a gruesome butchery.

Celebratory events are professionally orchestrated to show a panoply of symbolic expressions (gift of life) which transform the patient body in systematic greenery (harvest-explant-transplant) while obscuring death, human suffering, body commodification. At same time they systematically silence public grief of the families and deny individual identities of the explanted. An Orwellian newspeak has been elaborated in the explant-transplant business and an elaborate array of powerful euphemistic devices that obscure the commodification of the bodies: death is life and life is death, grief is love and love is grief. The organ is a new pump for the recipient, an exchangeable socio-cultural resource for the progressive sociologist, a spare part for doctors. What is an explant for surgeons is a gift of life for the donor associations. Donor associations are usually made of future and past recipients and their families and friends under the strict surveillance of the business. Media newspeak is evolving from donation to opportunity or more recently to duty. But for patient and family donation-explant is actually quartering, dissection, clamping, flushing and disembowelment.

The consent to explant should be given by a competent individual who has received the necessary information, adequately understood the information, who after

considering the information, has arrived at a decision without having been subjected to coercion, undue influence or inducement or intimidation (CIOMS International Ethical Guidelines). Consent should be a moral and legal requirement Comprehensibility should be essential but since proper information is considered too traumatic and even cruel it threatens the opportunity to acquire consent.

The leading German transplant surgeon used to say "If we inform the public properly we won't be able to procure organs any longer". But the new ethicists say that it is immoral to require consent for cadaver organ donation and that no one has the right to say what should be done to their body after death (H. E. Emson). They suggest the need to rethink our attitudes to the bodies of the dead in order to increase our willingness to donate organs and tissues (J. Savulescu) or that in organ procurement dead interests are less important that living needs and cadaver organs should be automatically available (John Harris).

Families however are not told that testing procedures hasten death. Families are not told that there is an ethical debate. OPOs do not believe there is an ethical debate. Substituted judgment is difficult and very few individuals understand what is involved in process. The interest of the dying to avoid being declared dead prematurely and to be treated humanely is sacrificed. Other people's interest to declare a dying person dead as soon as possible guaranteeing legal immunity for discontinuing life-prolonging measures and collecting vital organs is sponsored by the hospital corporations, medical profession, recipients and the transplant supporters.

Donor privacy is constantly violated by OPOs and coordinators who have the right to inspect all medical records and take the liberty to inform the media that organ have been donated. By contrast recipient privacy from the donor family is severely protected. Surviving recipients are then showed in talk show, events, and as trophy in medical meetings.

In the past people feared being buried alive. So it has long been understood that life can imitate death and vice versa. It was a matter of waiting long enough to be sure that the vital principle was extinguished and not just in abeyance. In the transplant era the push is entirely in the other direction. They want to speed up as much as they can the determination of death. Have they have gone the full circle from primitive, stone age cannibalism to high-tech cannibalism? Transplant business now imposes government legislation and achieves organs and money from the grieving families surrendering to donation. Its secular priests and acolytes visit schools and indoctrinate children with ghastly practices disguised as images of benevolence. They refrain from teaching how to prevent injuries but illustrate how masochistic altruism is socially acceptable, desirable and even mandatory. Animals including orang-utang and dogs are given more protection than dying children. Transplant enthusiasts hunt seriously injured persons like dogs in a starving pack gaze at an injured, bleeding dog. They appease their own hunger by attacking and eating the injured animal. Humans fall victims of their own trust in biomedical technology. It is common experience in our prestigious hospitals and universities: the self-proclaimed push for aggressive promotion/ education, aggressive referral, aggressive definition of death, aggressive consent pursuit (presumed-mandated-forced), forced donation. Even families have resorted to a compelled donation by minors or mentally retarded minors via the

courts. This is an encroaching, disguised cannibalism similar to that found in the animal kingdom.

Dying patients are not means to another's end, even a good end. Patients are persons, not an assemblage of spare parts. Part is an essential portion, not an accessory, of the whole. When speaking about human bodies, the part is precious to the owner whether the owner is the body in its current incarnation or the surviving bereaved family. Our dead are precious to us because ours is a species, for better or for worse, that has learned in thousand years to deal with death by dealing with our dead .

It is tragic that the ingenuity of human race has developed the transplant hypertechnology for prolonging some lives, and then discovering that medical profession and its patients longing for organs are descending to the level of the unconscious beast. Body hunting and harvesting by manipulative coordinators, double face surgeons, renegade re-animators, are lowering the human society into a techno-cannibalistic society. Democracy in science requires knowledge, respect, fairness, consensus, not undue influence, manipulation, deceptive consensus request or even force. Even the totalitarian States did not ask for consent before executions in order to acquire legal immunity.

The medical profession is not yet prepared to resist and counteract the ideological and organisational establishment of the macabre and repulsive ethical and surgical transplant bazaar. Unless a more open, not biased and democratic look at the business will be made, the transplant business will remain a new aspect of the totalitarian State with the same actors, excited bystanders, lascivious propaganda, and cruel methods similar to that of stone age cannibalism, medieval torture, and death penalty.

Only an informed public that closely works with technical professionals without any conflict of interest and their ethics counsellors without any conflict of interest can reach an opinion, make an informed choice, and most probably have the gut to say no to indecent proposals.

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