

The Borrowed Organ (-Donation) Reciprocities: Long Live My (becoming Other's) Body and Spirit!

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Who cares for (other's) human bodies – organ donation as an extension and/or representation of one's existence? This brief explores organ donation processes, focusing on the (virtual and real) socio-reciprocities among the stakeholders beyond organ donors and receivers; highlighting the contradictions, developing along the past, present and future historical timeline within a wider opportunities structure available in 20th-to-21st century. By discussing the socially giving of human organ to other person – transplantation-medicine promises for better survival outcome with the borrowed body part(s), it articulates that, bioethics for organ transplantation (OT) medicine, is struggling with socio-cultural traditionalism and governmental regulatory initiatives, not least the emerging market-force driven higher pricing for the best possible survival outcome for the living (and for the donor too), with both real and virtual (face-to-face or the absence of it) reciprocities between the organ(s)-donor and receiver(s) take place.

This brief examines the contradictions of modernizing living and organ-donation processes in Chinese communities Hong Kong, with reference to the Three-Level-Structure of Analysis on Bioethics. Taking account of socio-technological innovations, initial findings show that, the concerned parties (biomedical professional and the relatives of the potential organ donors, vis-à-vis those recipient-patients) act differently, if not contradictory, within their own self-referential temporal logic, belief and emotions -- juxtaposing the gate-keeping function of biomedical regime for (diagnosis -cum- prognosis) promoting “sharing” or “recycling” (parts of) human bodies, which has been increasingly instrumental to define, as well as shaping, the meaning (and part) of human, body and soul, physical life, even without an explicit nor a well elaborated- shared ethical-normative framework.

Key Words : Bioethics, Biomedicine, Human Body, Organ Donation, Transplantation

1. Questioning Whose Body-Parts to Whom in Hong Kong?

Against all the odds of trials and errors in experimenting organ transplantation, Hong Kong has its first cornea transplanted in 1961, followed by kidney in 1969 – which laid the foundation for live organ transplantation in the 1990s. The subsequent biomedical technology advancement provides hope for patients who are in need of other's organ to replacing their malfunction one; redrawing the boundaries and contours of the natural, vis-à-vis, the artificially transplanted organs, as well as redefining the ownership and usage of one's organ(s), readily harvested for other's survival. Yet, the bio-social

transformation thanks to new biomedical science has been complex yet highly differentiated with changing society-technology nexus in variety of cultural-localities, as this paper attempts to demonstrate.

1.1 The Western Medical Institutionalization for Organ Donation in Hong Kong

The legal foundation for regulating human organ transplant in Hong Kong is Human Organ Transplant Ordinance (Cap. 465) (HOTO; Hong Kong Law: CAP465, 1995-2012); it regulates transplantation procedures, and the use, for research and other purposes, of human organs. Accordingly, organ transplants in Hong Kong, from both cadaveric

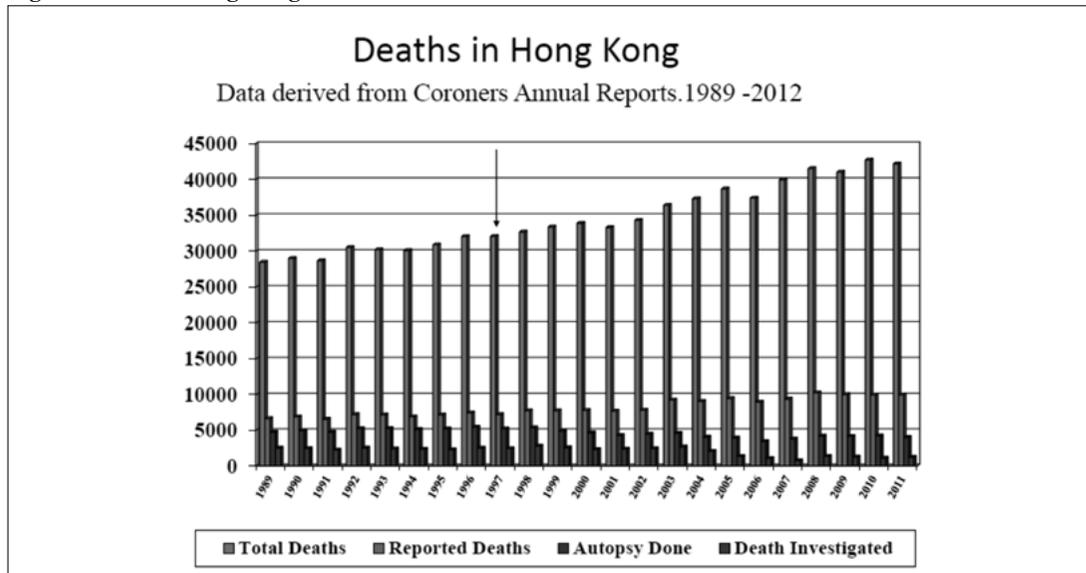
and living donations, are subject to regulation under the Human Organ Transplant Ordinance (HOTO), the main purpose of which is to ensure that no commercial dealing is involved in organs for transplant, the Ordinance aims:

- to prohibit commercial dealings in human organs intended for transplanting;
- to restrict the transplanting of human organs between living persons; and
- to restrict the transplanting of imported organs.

Hence, it is absolutely forbidden and illegal to perform any procedure for OT in commercial, market-pricing exchange or trading terms in Hong

Kong, despite its high biomedical application in mostly public run hospital milieu. More importantly, the harvest from dead patients without prior and familial consent is nor is not possible - that is very different from mainland China where the harvested organs from the dead are not uncommon within the state and black-market trading of human body-parts (Reuter 2013). More specific, organ donation is the only source for transplantation yet there is large potential for it as the death rate in Hong Kong has been on the rise due to its ageing population. How to secure people’s consent for donating their dead body-parts is the challenge for those-in-need survival.

Fig. 1: Deaths in Hong Kong



(Source : Beh 2013)

Fig. 2: Milestones of Hong Kong Organ Transplantation

Year	Organ / Tissue
1961	Cornea
1969	Kidney
1991	Liver
	Bone
1992	Heart
	Skin
1995	Lung
	Combined Heart & Lung

(Source : Hong Kong Organ Donation <http://www.organdonation.gov.hk/eng/statistics.html>)

For regulating transplantation, the Human Organ Transplant Board (HOTB), Board, a statutory body set up under Section 3 of the HOTO to perform the following functions:

- to consider applications made for the Board's prior written approval to carry out living non-related transplants (i.e. transplants between persons who are not genetically related or a couple whose marriage has subsisted for less than 3 years);
- to receive prescribed information about transplant operations;
- to receive certificates accompanying imported organs;
- to receive any information and documents that

by the Ordinance are required to be submitted or supplied to the Board; and

- to require any information or documents that the Board may require to be provided under the Ordinance.

1.2 Catching Up with New Biomedical Science: Government Policy-Oriented

In spite of all scientific endeavours and its biomedical advancement in Hong Kong, organ transplantation is minimally done, vis-a-vis, other life-saving medical procedures. The overall numbers of organ transplanted are less than 10% of those waiting for the transplantation (Fig.3).

Fig. 3: No. of Organ/Tissue Donations & Patient Waiting for Transplantation (2004-2013)

No. of Organ/Tissue	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	No. of patient waiting for transplantation (as at 31.12.2013)
Kidney donation											
Deceased donor	44	50	53	58	65	87	74	59	84	70	1991
Live donor	6	8	13	8	12	8	7	8	15	12	
Liver donation											
Deceased donor	20	24	23	26	26	43	42	30	45	38	120
Live donor	56	38	48	41	42	41	53	44	33	34	
Heart donation	7	8	7	5	6	10	13	9	17	11	17
Double Lung donation	0	2	1	1	1	2	2	1	3	2	18
Single Lung donation	0	0	0	0	0	0	0	0	0	2	
Cornea donation (piece)	230	214	244	198	211	203	250	238	259	248	500
Skin donation	30	13	8	13	19	17	23	21	6	4	Uncertain
Bone donation	4	3	3	1	1	0	6	0	3	3	Uncertain

(Source : Hong Kong Organ Donation <http://www.organdonation.gov.hk/eng/statistics.html>)

In all cases, the timely supply of the right organ is critical for any transplantation; Hong Kong's medical institutions are under such constraint. Here, there are many factors to shape, in shaping organ donation and transplant, whether transplants can be life-saving. In Hong Kong, the major medical and health service-provider, the Hospital Authority (HA), has mechanisms to handle and coordinate the clinical aspects involved in the process. But at the societal level, the key is still the attitude of the general public towards organ donation.

Yet, the legality bound procedure for human organ transplant is critical that, governed by the law(s) on human organs transplant, there are key requirements that

- Any arrangement or advertisement involving payment for the supply of a human organ intended for transplant is prohibited.

- Prior written approval must be obtained from the Board for any removal or transplant involving a live donor unless the donor is related to the recipient either genetically or by marriage which has subsisted for not less than 3 years.
- The prescribed certificate and supporting documents must be submitted to the Board before transplant involving the use of imported organs can take place.
- Information on all human organ removals, transplants and disposals must be submitted to the Board within 30 days after the relevant event took place.
- A declaration must be submitted to the Board within 30 days after the transplant involving an organ removed for the donor's therapy.

Given the limited supply of organs from the dead and living ones, Hong Kong government policy is

clear that it is advocating a culture of organ donation in our society. “When promoting organ donation as a commendable life-saving act, we do not differentiate between cadaveric and living donations. Nonetheless, for practical reasons and as borne out by statistics, cadaveric donations will continue to be the main source of organ donations”, as noted by the Secretary for Food and Health, Dr. York Chow, in Legislative Council, 1. June 2011. More specific, the Department of Health and Hospital Authority and various sectors in the community have been promoting organ

donation through different ways, including rallying support of community leaders from various sectors for organ donation, so that more people become receptive and willing to donate organs (Fig. 4). Yet the biomedical and legal complexity for OT is mostly beyond the reach of the general public, given the resource-limited, over-crowded, wait-listed, medical and health institutional setting in Hong Kong, and it has limited the coordination efforts to promote organ donation as a social virtue of altruistic giving.

Fig. 4: Organ Donation Form Sample

How to support organ donation?

Please record my wish to donate my organ(s) after death
(*Required Fields)

*Name: _____
 *HKID No.: _____
 Contact Address: _____

 *Hong Kong Daytime Contact Tel. No.: _____
 E-mail Address: _____

*I wish to donate upon my death: (Please tick)

All usable organs
 The following organs (please select one or more)

Kidney Heart Lung Liver
 Cornea Bone Skin

*Signature: _____

Attention

(1) Upon receiving your organ donation form, DH will contact you by telephone to verify your personal particulars. DH will issue a new form to you by post or via email using the address you provide if DH fails to establish contact with you.

(2) If you do not provide the requested information, DH may not be able to complete the registration process for you.

(3) Anyone successfully registered with the COOR office as a donor will not be issued any organ donation card, nor is he/she required to carry such a card around.

(4) If you have already registered with the COOR and would like to update your particulars or withdraw your registration, please re-submit the registration form or complete the withdrawal form online, by post or by fax. DH will update your record or cancel your previous registration after verifying your personal particulars by telephone.

Statement of Purposes for Collection of Personal Data

(1) Your registration with the Centralised Organ Donation Register (CODR) is a voluntary act. All collected data in the CODR will be classified as personal and treated with strict confidentiality for exclusive access by authorised personnel for the following purposes:

i. arranging organ and/or tissue donation and transplant;
 ii. performing relevant data management.

(2) Collected data in the CODR are mainly for use within the Department of Health (DH) but such data may also be disclosed to the relevant Government bureaux/departments or parties for the purposes stated in paragraph 1 above.

(3) Collected information in the CODR will be retained for 100 years from the date of collection, or until DH has acknowledged the death of the person whom the data refer, whichever is earlier.

(4) The organ donation registration form will be destroyed if DH fails to establish contact with you for verification of information, or after your personal data have been entered into the CODR.

(5) You have the right of access and correction with respect to your personal data as provided for in Sections 18 and 22 and Principle 6 of Schedule 1 of the Personal Data (Privacy) Ordinance. Your right of access includes the right to obtain a copy of your personal data provided by you during the occasions as mentioned in paragraph 1 above. A fee may be charged by DH for complying with a data access request.

(6) Enquiries concerning the personal data provided, including requests for access and correction, should be addressed to:

COOR System Administrator
 Department of Health
 21/F, Wu Chung House
 213 Queen's Road East
 Wan Chai, Hong Kong
 Telephone No.: 2961 8441
 Fax No.: 2127 4926
 E-mail Address: codr@doh.gov.hk

NO POSTAGE
 STAMP NECESSARY
 IF POSTED
 IN ENVELOPE
 無須貼上郵票

PRIVATE & CONFIDENTIAL
 BUSINESS REPLY SERVICE LICENCE NO.
 商業回郵號碼 : 7475

DEPARTMENT OF HEALTH
 COOR SYSTEM ADMINISTRATOR
 21/F, WU CHUNG HOUSE
 213 QUEEN'S ROAD/EAST
 WAN CHAI
 HONG KONG

POSTAGE
 WILL BE PAID
 BY LICENSEE
 郵票由持
 牌人支付

(Source : Hong Kong Organ Donation <http://www.organdonation.gov.hk/eng/statistics.html>)

2. The Differential Embodiment of Organ (-Mobility) in Hyper-Modernizing Asia?

The availability, or sufficient supply, of human organs is the pre-condition for any transplantation procedure to secure another patient’s survival. Hence, it is a somewhat one-way traffic for OT that critical timing is the very essence for sourcing, harvesting and subsequent transplantation of human organ – strongly argued by many medical professionals, the living donors-sourced transplantation is a good

strategy that allows the optimal timing, and clinical procedure, for OT, and it may potentially lead to better outcomes (Abidin et al. 2013; Chan WM 2013; Lo 2012a).

For this, the fundamental is the donor’s willingness to donate the organ for another (mostly unknown) person who is in critical sickness. Yet all psycho-social conditions prior to the decision-making for organ donation are both intrinsic for herself / himself, juxtaposing her/

his networking and influences from others within a wider social milieu. Hence, the interplaying of the intertwined relationships with oneself to his/her social reciprocities should be stressed here – the donor's decision-making though is within the realm of clinical procedure for OT, it is more socio-historically rooted or anchored in one's socio-familial reciprocal network who has less control over – and mostly as expressed in terms of the worldview on one's (donor's) own, vis-à-vis, the other (patient) survival. Comparatively speaking, the harvest of human organs from the dying-to-dead one is more likely for the "donation". The obvious genesis for one' organ donation is beyond the end(ing) of life – organ donation after one's dead – below is an illustration for dead-body donation for medical research for (larger common good of) humanity.

2.1 Whose Dead Body for Medical Research: My, Your or Other?

Buddhism, Confucianism and Taoism (The Trilogy of) in Chinese culture have differential, and more often than not contradictory, influences on the essence and ontology of human body for both organ donor and recipient, as well as their family's interpretation on body-parts and spiritual-soul: their differential intertwining interplay acts positively for, and sometime negatively against, OT.

For example, Confucian (sometimes contradictory) ideas (-cum- ideal) that one's body is not one's body, but deriving from his/her parents, in terms of the fundamentals of filial piety – "my body is from my parents" 《孝經》“身體髮膚 受之父母 不敢毀傷 孝之始也”. To highlight this, a case study (Chiu et al. 2012) on the attitude for body donation, after dead, for medical research is illustrative:

In spite of her Chinese cultural background, she does not hold fast to the whole-body-integrity belief of Confucianism, and protecting the integrity of her body was not an important factor in her decision to donate her body. She understands the dissection process and how her body will be handled, but she does not think filial piety is violated by the dissection of her body. She thinks that dissection is essential for the education of medical students and research development in Hong Kong (Chiu 2012: 296).

Hence, Confucian ideas or ideal for preservation of an intact body after death shape familial objections for organ donation. That might be the important factor making the organ donation rate as

low as 3 per million population per year in 1980s to early 2000s.

Anecdotal data of the dead-body donor-registration (for one's own dead-body for medical research) was extremely low, though it has been improved to 600 in January 2013. Facing the crisis of the limited supply of dead bodies for medical education training: after a full community-wide campaign questing for dead-body for medical research, the registration gone up to 2,500 in September 2013 (Chan LK: 2013; Chan WM 2013). During the campaign, one professor from the Medical School at The University of Hong Kong stressed that “We need a minimum of 20 corpses every year. Our body donation programme was launched 40 years ago. In the past few years, we have only received three to five donated corpses“.

But still, there is enigma about any possibly change of social attitude towards body (organ) donation after death – might be thankful to the good mixed-form of this trilogy, and the rightly re-interpret some other teaching from the trilogy of Chinese traditionalism and local folklores, to motivate potential body donors in Hong Kong. Undoubtedly, the influential forces are mostly from family members, medical professionals' relationships to patients and donors: still, social ethos and norms, expressed in terms of the contradictory public attitudes to new technologies, essence and meaning of life (and survival) in the organ-transplant matrix of humanity.

2.2 The Biomedical Proceduralism in OT Timing: Social Trust Reciprocities?

Obtaining (expressed or prior) consent is the most challenging task to increasing the number of cadaveric and living organs for transplantation; particularly in choosing Who, When and How to obtain the consent (from Whom - Which Family Member?) are the questionably procedural enigma for all stakeholders – it is obviously from historical data that there are less than 5% of (from both the dead or living donors) kidney being available in Hong Kong. This is further complicated by not just biomedical (versus) considerations within the matrix of the fragile and contingent psycho-socio-familial reciprocal networks for both donors and patients, but also the situation-procedural specific, time-bound legal and biomedics for organ transplant: in short, there are too many stakeholders in shaping the donation procedure and processing for OT.

Public intervention, as legal procedure undertaken by governmental agencies (say the HOTB as stipulated by the law of HOTO) in OT represents the only societal basics (of forbidden commercial trading of organs) for, and higher order for social virtue of, the common good to save life, in addition to the mutual yet distinct consent from both organ donor and recipient respectively – beyond or not the one following a market-driven pricing for the body-parts.

In addition to the legal requirement for mutual consent for undertaking the risk and responsibility for both donating and receiving partners, the only condition for working (though not imply 100% success) out OT is the mutual trust between donor-recipient to or through medical professionals who are coordinating and operating the organ from one body to another one, yet in double-blind asymmetric, donating to receiving relationship - this is also extending to family-relatives network of both involving parties. Obviously, the double-bind conditions (of not knowing where the organ(s) goes to whom, and not to knowing where the body-part is come from) make a unique ethically-ground gatekeeping position for medical professionals who are merely bound by their own bioethical logics not just for operating the OT – but at the same time serving as a “fire wall” between the involving partners and their respectively socio-familial network. And the mutual trust-based firewalling effort is merely expressed in terms of the gratitude from the receiving ends and the belief of donation for serving or saving others; all are reflecting as the altruism of humanity at large. Yet, to maintain such mutual trust requires much societal endeavours, not least the consensus, derived from social reciprocities across different social timing and human interaction within and beyond one particular cultural space-milieu.

Build up mutual trust, as if in old traditional community, in a globalizing world is already a mission-impossible challenge. But the idiosyncrasy of Hong Kong is more complicated by its own history and socio-economic changes, transforming from a fishing village in 1850s to 21st Century’s super-modern city in Asia (Lai 2013)... Yet, the small number of registered donors (of ca. 141,000 in February 2014) in Hong Kong reflects its socio-economic conditions, and the predicaments, to build up the necessarily mutual trust for timely OT. It is undoubtedly a daunting task for Hong Kong, a southern Chinese (Cantonese speaking) migrant

society in advanced capitalism, to foster some form of (rejuvenated yet emerging?) mutual trust among people – particularly for trusting onto the Westernized medical professionals whose lingua franca is mostly in English with foreign biomedical scientific knowledge, all beyond the reach of many people.

2.3 Organ Donation (–Campaign): The Surviving (Beyond) Life Reciprocities

Against the dominant mode of monetary exchange in global advanced capitalism, the market for human organs trading is under-developed in most modern societies and in most cases, the for-profit business model for OT is forbidden – this is somewhat contradictory to the essence of hyper-modernizing societies in a globalizing world of everything has a price (tag) – readily to be sold and bought: how much or can there be body-organ pricing over human values?

For modernizing societies, societal consensus for organ donation is still developing and the commercialization of organ trading or sourcing is not fully addressing to – one major step for many developing economies towards modernization is to legally forbidden organ-for-sale and trading.

For majority of OT, it is thankful for altruistic organ donation without an open (though there is existence of black) market for human body-parts trading. Hence, the altruistic value for organ donation has its supremacy in terms of humanity (in modernizing and civilization terms) over the alternative of profit-driven market mechanism with money-price-based organ trading and exchange. The exclusiveness for OT is enshrined through detailed legality bound procedures, as well as the biomedical proceduralism rooted in bioethics and scientific advancement. But in Asia, there is still varieties and difference among societies, in terms of organ-donation regulatory controls and frameworks (Abindin et al. 2012; He et al. 2010 see Fig, 5).

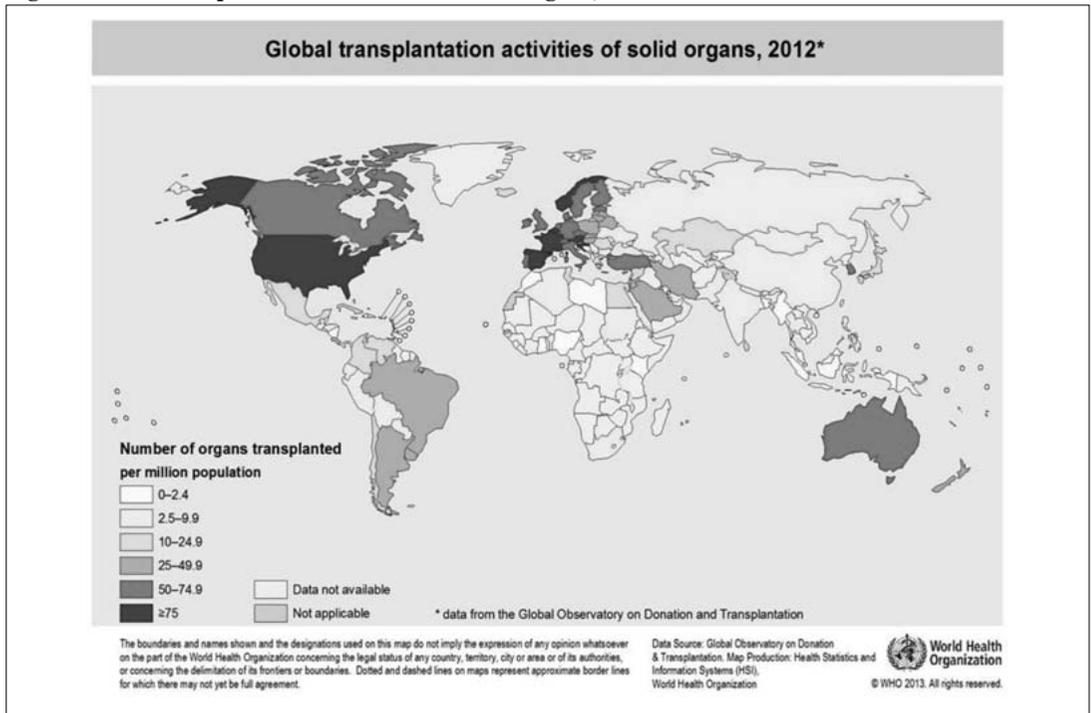
Fig. 5: Living Donor Transplantation Policy in Asia

Economy	Donor restriction				Donor compensation	
	Living related			Living unrelated	Compensation	
	Immediate family	Close relatives	Emotionally attached		Kidney	Liver
Mainland China	Yes	Yes	Yes	No	—	—
Hong Kong SAR	Yes	Yes	No	No	—	—
Iran	Yes	Yes	Yes	Yes	\$2,000-4,000	N/A
Japan	Yes	Yes	Yes	Yes	—	—
Korea	Yes	Yes	Yes	Yes	—	—
Malaysia	Yes	Yes	Yes	No	—	—
Philippines	Yes	Yes	Yes	Yes	—	—
Saudi Arabia	Yes	Yes	Yes	Yes	\$13,300& other benefits	
Singapore	Yes	Yes	Yes	Yes	Still in discussion	
Taiwan	Yes	Yes	No	No	—	—

(Source : He, et al. 2010)

But the advanced scientific knowledge might be wrongly interfacing with the local culture, shaping the low rate of organ donation and OT performed: partially by the passivity among health professionals in engaging potential donors and their families,

as represented by the comparative low rate of organ donations from dead and living donors, as well as OT, in Asia – monitoring from the Global Observatory on Donation and Transplantation (GODT 2014) confirms this (see Fig.6).

Fig. 6: Global Transplantation Activities of Solid Organs, 2012

(Source : GODT)

Yet, there are cultural traditionalism and developmental (pre-modern belief) barriers for many Asian societies to echo the new calling for organ donation – to save other's life; and Asians are more reluctant to donate organs than Caucasians:

Within Asia and even within individual countries, there are numerous ethnic, social, cultural, and religious factors contributing to disparities in deceased donation. In China, for example, Confucian values and, to a lesser degree, Buddhist and Daoist beliefs, which associate an intact body with respect for ancestors or nature, have been shown to have a negative effect on the overall willingness to donate. On the other hand, there are striking differences in attitudes toward organ donation in various Muslim communities. Some religious thinking discourages deceased donation because of a sense of the sacredness of the body or a fatalistic approach to illness. Nonetheless, the commercial sale of organs has been widely reported in some Muslim countries (Lo 2012b).

Obviously, local traditionalism provides differential barriers and inertia against (or alternatively supports for) new biomedical offerings to keep individual survival by OT and extending their humanity. The traditionalism against the separation of body-part(s) outside oneself, the least to another foreign body, limits the workable living and dead body-part OT. Historically, the limited OT in Confucianism shaped East Asia societies is a good testimony. But the same traditionalism for filial piety is undoubtedly a good partner for modern bio-reproductive technology to reproducing more for familial successions, as far as the functionality and instrumentality for the family survival. Here, assisted reproduction as an acceptable though not ideal, solution for family reproductive succession is along the patriarchy social contours: human reproduction (through various ways to create offspring) in Chinese societies has more than the instrumentality to realize socio-cultural virtues of filial piety and patriarch family succession, while reinforcing intergeneration contracts for family and kinship (Lai 2013).

The obvious question to overcoming the limits of traditionalism for human development is: as biomedical OT enables a better chance for individual survival but the question is where to have the matching-organ timely: could the new biomedical technology of OT become a boost for Chinese (traditionalism for) survival? How a biomedical link to bridge the thousand-year old tradition with OT-

enhanced humanity?

Critical engaging with traditionalism for developing new norms for humanity common good, thanks to new biomedical technology, is a challenging one. The social virtue, and for the good deed of individual, for other human being survival, expressed in terms of “Organ Donation Saving Lives”, are the key values in advocating the culture of donation of human body (in full after dead) and parts (organ for transplantation during one's life course). Since mid-2000s, medical professionals, NGOs and organ-transplanted survivors have been very active in organ donation campaign in Hong Kong (HKST, Nov.2013). To promote organ donation after death, Hong Kong Government has lately established the Centralised Organ Donation Register (CODR) in November 2008. The Register helps authorized personnel (such as the Hospital Authority's Organ Transplant Coordinator) to timely consult and solicit for donor's consent, as well as coordinating with medical agencies for organ harvest and transplant, benefiting those waiting-listed patients and their family: there were over 141,000 registrations recorded CODR in February 2014. This progressive development is also benefited from a more pro-active approach by medical professionals who take the lead to inform the public through real life stories about the importance of saving someone (family as well) life with OT – the opportunities to serve a larger world with the donation of human organs at the end of life, or at the ending of life with clinically brain death (Chan WM 2013; See Hong Kong Government–Organ Donation Homepage for details).

Obviously, this is in line with the continuing health education and highlighting the role of the organ transplant agency to building up functional linkages between (potential) donor-recipients, their families and medical professional, as well as increasing the public awareness through cultural, religious and mass media, are essential in improving the rate of organ donations from deceased and living donors in modernizing Asia (Abidin et al. 2013; GODT 2014; He et al. 2010).

3. Trilogy of Organ-Transplant Bioethics and Reciprocities in Hong Kong

To examine the contradictions of modernizing living and organ-donation processes in Hong Kong (under colonial-capitalism and mainland China under state-nationalist-socialism), the following sections

addresses the Three-Level-Structure of Analysis on Bioethics. For understanding the dynamics of new life-making thanks to transplantation, we examine three inter-related spheres, mirror-imaging the Beauchamp (2003; Beauchamp & Childress 2008)'s three levels of biomedical ethics and the related structure, with specific reference to some distinctive yet inter-related mechanisms for coping with the transplanted body part(s), the “add-on”, of human beings; namely, the interactions between/ among biomedical technology gate-keepers and their clienteles, within the temporal (timing, when and how long?) and spatial (where transplant technology and its derivatives take place: from microscopic donated, plus to the borrowed, body-part(s) domains, along the genesis-timelines of new body-part(s) in hyper-modernizing society (Lai 2013).

Obviously, in our framework, there is a strong sense for new emerging opportunities structure thanks to differential modernization trajectories on the one hand; and the rise of the varieties of second modernity (Beck & Grande 2010), on the other. For Asia's modernization drama, Hong Kong exemplifies such – the very obvious paralleling (or partial) Westernization of Japan, China and South Korea demonstrates the thousand-year old socio-cultural structure and dynamics embedded in hyper-economic growth of the (Western?) modernization trajectories (Chang & Song 2010; Han & Shim 2010; Suzuki, et.al. 2010; Yan 2010;). More specific for indicative illustration is illustrated as follows (see Fig.6 illustration)

Fig. 7: Dynamics of Organ Transplantation in Asia

	Inter-Corporeality & Temporality of OT When & Timing Issues	Agencies for (Against) Organ Transplant (OT) Stakeholders' Bioethics	Internality - Externalities Where: Arena, Setting & Domains
1st Level <i>Locale of Egg-Sperm</i>	Dead or Living Body-Part(s) availability – Patient(s) in Waiting	Modern Biomedical Science & Agencies	Body's Inter-Change from Donor-Patient – New Life Course Bio-Engineering
2nd Level <i>Bio-Tech In Society</i>	Regulatory Framework (e.g., HOTO, HOTB) within a Territorial-bound Jurisdiction (Country and Regional-State)	Biomedical & Legal Regulatory Framework for OT, vis-a-vis Donors - Recipients of OT, Faith-based Institutions like Church....	Clinical Settings & Networks of Somewhere: Licensed or Outside-the-territory-bound Transnational O.T.
3rd Level <i>Transnational Cross-Cultural Philosophy</i>	Historical Processing of Socio-Cultural Virtues of the New Human Body of Organ-Reuse+ Recycled: Global Opportunities Structure for Transnational OT	Transnational Agencies & Cross-Cultural Dynamics in a Globalizing World: Organ Traders and Market versus Altruistic Human Giving: The Gift Relationship in Fluidity of Family, Kinship and Lineage System?	Regional & Global Scales: New Life Course: Bio-Social Engineering and Extended Humanity with reused-New Body Parts? Interactions and Transformation between Scientific Knowledge Cultural Spheres

3.1 The Enhanced Human Body – Organ as a Transferable Biomedic-social Process

For the arena of the First Level of Analysis, human organ donation, transfer and transplant is considered as biomedical-social process within the health care institutional setting. Within the given institutional arrangement and procedure: giving the old body-part(s) to another human being, or new life, is embedding the formation of both “intra-corporeality” (within one’s body-corpus) and “inter-corporeality” (between bodies-corpus), more even so for the new (alternative) genesis of life form, twining more complex nexus with natural evolution and artificial adding-new bodily-enhancing.

body-part(s), as long as they are surviving, they are always under stressful conditions, before, at and after the transplanting-procedure; so do the relationships among their families and relatives: say the least is the emotional tensions, the ups-and-downs of psycho-somatic stress before-and-during the transplantation.... Beyond personal and familial nexus of emotional attachment; it is the donor's and recipient's dynamics and their unique family history, vis-à-vis, the “business as usual” for OT professionals, which shape not just the complex process of novice human-part(s)-regeneration, but also redefines the essence of humanity as (to be) experienced by the (passive) recipients of new biomedical treatment-solution with adding-on, or the loss of, body-parts.

For both donors and those recipients of human

There are two contesting arenas following the relationship of human body transplantation with the inter-corporeality and temporality, agencies for (against) biomedicine, and the related externalities. First, thanks to OT biomedical science miraculous advancement, human body-parts, organ(s) in particular, can be replaced from the old-body to the new one, as compensatory or add-on parts, as if humanity is machinery. But the possibility of saving one's life by OT is contingent upon the cooperation between and among all concerned parties – guided by health professionals: the functional relationships between the donor-and-patient, as well as their families are important. Yet, the relationship-building and maintenance among stakeholders are much not influenced by the differentials among agencies which/ who hold different (Western) medical knowledge and (Chinese?) traditional beliefs and ontology on human body-cum-soul. With the given low rate for organ donation and OT in Asia, Hong Kong in particular, there are many unanswered question about the interfacing, and possible synergetic benefits, between the donors and recipients.

Second and obviously, there is great challenge for health professionals in approach families of potential donors (beyond the health institutional settings of hospital and clinics), to “solicit” the valuable human organ- parts for OT, as the organ(s) is not just having the bio-physical properties (say, living or death of brain-stem) but it is (they are) the integral embodiment of human souls and spirits, well beyond biomedical sciences can addressing to. The ambivalence on human organ donation, for both living and dead bodies, is reflecting the ontology and spirituality of human beings – which can hardly be comprehended in terms of contemporary biomedical sciences; and the ambivalence is expressed in terms of avoidance or the passivity among health professionals in approaching potential organ donors and their families before, during and after the life-ending process (the socio-familial timing complex): wrong timing for “soliciting” the soul-cum-spirit embodied human organ(s) for transplantation. This can be shown by a recent survey of health professionals in Malaysia – which is illustrative about the complex (of socio-familial timing and organ-embodiment of human spirituality) for “soliciting” human organs:

Four hundred and sixty-two questionnaires were completed. 93.3% of health professionals acknowledged a need for organ transplantation in Malaysia. 47.8% were willing to donate their organs (with ethnic and religious differences).

Factors which may be influencing the shortage of organs from deceased donors include: non recognition of brainstem death (38.5%), no knowledge on how to contact the Organ Transplant Coordinator (82.3%), and never approaching families of a potential donor (63.9%). There was a general attitude of passivity in approaching families of potential donors and activating transplant teams among many of the health professionals. A misunderstanding of brainstem death and its definition hinder identification of a potential donor. (Abidin et al. 2013: 187)

To recapitulate the under-optimality for OT in health care institutional arrangement in general and health care professionals in particular, all reflect the complex, if not chaotic, conditions where, how and to whom is the OT process direct to. Hence, there is urgent need to re-consider OT as an interfacing process among various socio-cultural agencies, as well as the psycho-social intermediaries in and beyond health crisis conditions whereby human organ(s), many parts of our body at large) are not just in great demand for other person's survival, but also the explosive ethico-emotional dynamics to spill-over onto rational sciences of biomedicine and law.

3.2 Beyond the Bio-Medical (vis-à-vis, Socio-Cultural) Realm for OT

For the Second Level of Analysis, we wish to point out the following distinct yet interrelated contradictions. First, the biomedicine for OT is only available at the public health institution with strong state regulations but most decision-making (particularly) for organ donation is anchored upon the enigma of psycho-familial and cultural predicaments. Second, the administrative regime for OT is biomedical and legal- specific proceduralism without fully recognizing the complexity of human (individual) specific reciprocities to determine how and when organ-donation takes place. Third, the critical timing for biomedical procedure for harvesting-transferred and transplantation is differentiated, if not conflicting, from human individual's offering for organ donation. Last but not least is the de-coupling between medical ethics for biomedical professionals are somewhat less transparent in terms of the proceduralism of institutional guidelines and protocols, from the perplexing social norms and psycho-social reciprocities of human agencies.

Sourcing of human organs has been a critical issue for any OT, more even so for ethical and morality issues concerned – as no such market ever exist (GODT 2014; He et al. 2010). In East Asia's newly developed economies, living donor liver transplantation (LDLT) has been developed as an alternative (the only choice!) to overcome the problem of organ shortages, particular in the case for Acute Liver Failure (ALF):

Previous studies from Korea and Hong Kong, however, have shown that less than 10% of listed patients with ALF in Asia will receive a deceased donor liver transplant. The overall wait-list mortality rate is 45% to 60%, and this rate is markedly reduced if there is a potential living donor who has undergone an evaluation. Japan has an even lower deceased donor rate than Hong Kong and Korea. There were only 3 deceased donor liver transplants for ALF over an 11-year period, and 209 of 212 transplants (98.6%) for ALF came from living donors: this strongly indicates that there is no choice but LDLT in Japan. This contrasts sharply with the findings of the Adult-to-Adult Living Donor Liver Transplantation Cohort Study from the United States, which recorded only 10 LDLT procedures for ALF in 9 liver transplant centers over a 9-year period. LDLT for ALF is rarely needed in the West (Lo 2012a: 1006).

From the above discussion, the critical question is clear: social reciprocities for OT are beyond the limits of health institutions. Organ donation processes, have both virtual and real socio-reciprocities among the stakeholders beyond the organ donors and receivers; highlighting the contradictions, developing along the past, present and future historical timeline within a wider opportunities structure available in 20th-to-21st century. More specific, the novice social giving of the organ to other (mostly unknown) person – the OT promise for better survival outcomes with the borrowed body part(s), implies that, bioethics for organ transplantation medicine, is struggling to catch up with both governmental regulatory initiatives and the market-force driven higher pricing for the best possible survival outcomes for the living (and for the donor too), with both real and virtual (face-to-face or the absence of it) reciprocities between the organ(s)-donor and receiver(s) take place.

3.3 New Body-Part(s) in Gift Relationship Rejuvenates Old Social Reciprocities

For the third level of analysis; it is the rejuvenation of social virtue of giving: the innovative biomedicine enables social virtues like giving one's own body-part(s) to other(s) to upholding old functional social reciprocities, for the common good.

As socio-technological innovation OT opens up new spaces for the concerned parties (biomedical professional and the relatives of the potential organ donors, vis-à-vis recipient-patients) act differently, if not contradictory, with their own self-referential temporal logic, belief and emotions -- juxtaposing the gate-keeping function of bio-medical regime for (diagnosis -cum- prognosis) promoting “sharing” or “recycling” (parts of) human bodies. The dynamics and processing of OT have been increasingly instrumental to define, as well as shaping, the meaning (and part) of human bodies physical life, even without an explicit nor a well elaborated- shared ethical-normative framework.

More specific, the processes for human bodies' transfer re-constitute new identities for human beings (the body) -cum- the meanings of life and (from the) death (one) on the one hand, and the socio-cultural reciprocities in terms of *the Gift Relationship* (Titmuss 1971) between anonymous donors and recipients. Following the altruistic blood donation relationship between anonymous donors and receivers, the “Gift Relationship” coined by Richard Titmuss (1970), is an integral part of humanity (ethics and norms) which is beyond economic calculation per se. Yet compared with blood, risks for organ donation are indeed higher for both living donors and patients - an integral part of new biomedical asymmetric (one-way) partnership from the organ-donor to the recipient and the irreversibility of losing the organ for the former partner. More importantly, the risks of asymmetry and irreversibility at the critical stages of OT is exemplified by the so-called “near-miss” condition – aborted hepatectomy or potentially life-threatening “near-miss” events where a donor's life may have been in danger but no long-term sequelae occurred, is highlighted in a study that in a 126-“near miss” events,

approximately one in every 92 procedures. There were no differences associated with geographic regions. This rate is likely an underestimation representing those most memorable to the reporting individual, but this report does represent the first comprehensive report of actual

risks faced by donors across various health care systems and practice models. The actual reported events are those commonly reported after liver resection such as bleeding, biliary injury and thrombotic events. High volume centers reported larger numbers of “near miss” events, but when indexed to number of LDLT procedures performed, rates at high volume centers were significantly lower than either low or moderate volume centers. This suggests that a prolonged learning curve, significantly more than the previously reported 20 LDLT cases (3), is needed to maximize donor safety (Cheah et al. 2013: 505).

Given the limited supply of organs from the deceased donation – the alternative sourcing of human organ from the living one, and without affecting the donor’s health, is preferred for better chance for successful transplantation. More specific, the interfacing of the donor’s organ and the patient’s need are highly contingent upon the timing and complex clinical considerations: the acute organ transplantation provides only a very narrow time-space for meeting the specific supply and demand of a particular type of organ in biomedical clinical terms – the timing of deceased donor organ transplantation is dictated entirely by dying but not yet dead one – the God’s will so to speak. In contrast, living donor one not only permits early or timely transplantation and thus can prevent wait-list mortality: the donor-organ evaluation and the related biomedical clinical preparations can be better planned and completed prior to actual OT (Lo 2012a, cf. Cheah, et al. 2013; Grant et al. 2013). Here, the comparative advantages for good preparation and planning for psycho-social needs and adaptation for the living donor(s) and the surviving patient(s), and their families, are more than obvious.

3.4 New Biomedical Science: Organs Escape from a Globalizing World?

The 21st Century biomedicine has yet to re-produce human organ, though much advancement in regenerative medicine, like the development iPS cell and others, but many of the replacements of human organs need support from donors who can scarify themselves for the common good. Human wishes and preferences are far from rational, and are subjected to social-culturalization of the values and meaning for organ donation. Hence, the choices for the individualized way(s) to prolong one’s life are more likely thanks to biomedical sciences.

The offering of the “add-on” or “replacement” of human body-parts (organs at large) in new biomedicine for people, empowering the continuing of humanity in many ways; not least the new or extended life with the possible replacement of major human organs. People likely will choose for new lifestyle(s) and opportunities to make up the lost of (reversing or rejuvenating biological) critical time (for having replacement or new organ) set by bio-historic limits.

At the society level, there is new opportunities structure supported by both wealthy groups and biomedical science advancement for human life extension beyond the wear-and-tear of the organ parts – demonstratively an extension of people alternative choice(s) to make for planning one’s future (and legacy) and pro-(longing the) life course. For instance, people can now re-use any human organ at anywhere - anytime (back to the future?) as they wish, given new biomedicine-stored up “other” (once owned) body-parts. Obviously the question is whose body-part(s) is to be chosen for OT – whether this is only for those privileged ones.

This is in line with hyper-modernizing systematic calling for individual(ism-driven self-) planning future in liberal, global advanced capitalism: one who can still be active as ageing (say, reactivating their body with new replacement of human body-parts and organs). Hence, a new choice-based autobiography in “New Biomedicine Age” is more than obvious. The choice biography concept implies not just young people, but also the aging ones, to (re-) plan for their own (not historically defined, aged-limited and standardized life course). All these exercises are not just cognitive-mental one, but could be institutionalized into everyday life that people make alternative-planning of their own life course with new *Weltanschauung* (worldview) – the biographization of one’s own life course (Vinken 2004; Macmillan, Ed. 2005).

Helping the self-biographization of life course of younger generation are the state policy, new sciences and new family-wealth and outlook in late 20th Century (Lai 2013). Both the state and the upwardly mobile, better-off family (in comparison with their previous cohort) dynamics reinforce to reproducing new life beyond the historical bound age-limits. On the other hand, the apologetic and sympathetic attitudes of new, secularly individual rights-based regulatory framework for OT, foster new life rejuvenation even at advanced (60+) age

cohorts. Furthermore, most developmental state's further investment for biomedical sciences (as future championing technologies of life sciences) reinforces the complex, but contradictory, constellation of the individual's life choice for new-bionic humanity; calling for new challenging (constructive destructive forces?) biomedical technological advances. One such complex matrix is a challenge to social (historical bound) norms and ethics on the equal opportunities for men and women (for life creation), with the promotion of progressive rights for everyone's sovereign body (and parts) for new human organ(s) to be harvested, reused and replaced.

With new biomedicine, contradictions are inherently embedded in economic hyper-developmentalism under the so-called globalization processes; challenging the formation of the "we" sense of belonging in many communities (undergoing destruction, if not broken up for transformative development); which is essential for the development of organ donation "culture". The calling for the "borrowed organ" for extending -cum- saving human life might be one of social virtues of human sacrifice – which has nothing to do with research and development asset and capability one society endowed. Likewise, they are more or less social processes for social formation of good wills for the other anonymous donors and unknown recipient, regulated by a given set of biomedico-legal framework anchored upon the agreeable ethical -cum- local-justice principles in one's social milieu. But the consensus building process is a challenging, if not impossible, one given the highly flexible socio-economic activities and mobility of people socio-geographically in hyper-modernizing, economic, developmentalism in East Asia where communities have been transformed in the last 30-plus years.

4. Alternatives beyond Transplanted New Life – Searching Organ or Soul-Searching?

Our case study shows Hong Kong society with Chinese (local-)traditionalism is meeting up the challenges, and catching up with the rejuvenated social virtues for donation, of newly biomedical sciences from the West; not just in terms of positivist science and knowledge but also the very essence of ethics and norms which have been undergoing transformation in the last few decades (cf. Lai 2013).

Taking account of socio-technological innovations, our initial findings show that, the

concerned parties (biomedical professional and the relatives of the potential organ donors, vis-à-vis those recipient-patients) act differently, if not contradictory, within their own self-referential temporal logic, belief and emotions -- juxtaposing the gate-keeping function of bio-medical regime for (diagnosis -cum- prognosis) promoting "sharing" or "recycling" (parts of) human bodies, which has been increasingly instrumental to define, as well as shaping, the meaning (and part) of human bodies physical life, even without an explicit nor a well elaborated- shared ethical-normative framework.

Our critical remarks are: the processes for human bodies' transfer are reconstituting new identities for human beings (the body). Futuristic biomedical science in 21st Century hypermodernity, for Hong Kong's catching-up modernization in particular, facilitates not just new technologies but likely to transform humanity with rejuvenations of multiple (partial organs) of humanity, new bio-medical parts from other bodies, with emerging novice technology-driven societal encounters, like new virtual realities and the back-to-the-future human relationship when traditional family-kinship can be historically or chronologically reversible: any living parts from cells to organs can be possibly re-cycled and re-made by biomedical re-engineering....

This paper starts with the question: who cares for (other's) human bodies – organ donation as an extension and/or representation of one's existence? It examines organ donation processes, focusing on the (virtual and real) socio-reciprocities among the stakeholders beyond the organ donors and receivers; highlighting the contradictions, developing along the past, present and future historical timeline within a wider opportunities structure available in 20th-to-21st century. Highlighting the social giving of the organ to other unknown person – transplantation medicine based promise for better survival outcomes with the borrowed body part(s), it articulates that, bioethics for organ transplantation medicine, is struggling to catch up with both governmental regulatory initiatives and the market-force driven higher pricing for the best possible survival outcomes for the living (and for the donor too), with both real and virtual (face-to-face or the absence of it) reciprocities between the organ(s)-donor and receiver(s) take place.

For the likely scenarios in future: the quest for human survival is the essence for organ transplant in Asia. Living donor transplantation has developed

because there is no choice and it is rightly noted that: “Is it possible that it may in fact be a better choice?” (Lo 2012a: 1006) Furthermore, the quality of a living donor’s organ is highly selective therefore good in quality, enabling a good prognosis with less complication -- such a strategy may be a good alternative, if not advantageous, for needy patients even in societies with adequate supply of the deceased donor organs.

Yet far from the paradigmatic shift towards the Western one, there is emergence of more alternatives – thinking -cum- thoughts on enhancing survival opportunity for everyone in need (of extra, replacing human organ): new differential meaning(s) of life for *homo sapiens*, happiness and wellbeing after the deceased whose body-parts still live in another person-body - human beings survive!

Our case study on Hong Kong highlights certain salient features of socio-cultural (*vis-à-vis*, Chinese traditionalism) and (Western) legal catching up of the advancement of Western biomedicine: the belated legal framework establishment in mid-1990s (1996-2012) while various OT breakthroughs were made in early 1990s - before the law legislation; and the rediscovery of the social virtue “to give” (donate one’s body-part after dead) in the “gift relationship” – to maintain socio-cultural-familial bondages with OT, since 2010s; paralleling the biomedical professionals’ engagement (for their own vested interest?) in public sphere to promote organ donation during the crisis of not-having enough body-parts for carrying out their mission (business practice?).... But there are more questions than biomedical science can deal with: with more organs available – thanks to the altruistic donation, this will transform the practice(s) for OT in future, as the legal-biomedical proceduralism will likely be challenged by more supplies of organ. The change is likely not just from the under-supply of the organs to the optimal supply, but towards a regime which quests for highly selective screening (in terms of DNA genomics) for better quality human organs, with a likely shift from the public-altruistic “gift relationship” to a highly selective one with more choice with screening - though it is far from the private-commercialization biomedical (taking the comparative advantages of the cross borders trading for) OT. The enigmatic paradox seemingly comes back in full cycle - for humanity (embracing both body and soul) survival: Whose (one’s or the other’s) and what (which body-part) bioethics for whom?

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