LEGA NAZIONALE CONTRO LA PREDAZIONE DI ORGANI E LA MORTE A CUORE BATTENTE

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nata nel 1985

PRESS RELEASE
YEAR XXII – n° 8
19th September 2006

J'ACCUSE
AGAINST THE HEART-BEATING BRAIN DEATH

The Will to save the organs at all costs
Kills the Will to save the patient at all costs

So said "brain death" constitutes the central pillar on which the explants-transplantation procedure is based (1). Without it, replaceable surgery based on the explant of organs from **alive subjects** who lost their consciousness would not be granted any status. The artificially ventilated patients, arbitrarily defined as "corpses" by the doctors pronouncing a "brain death" predicament, are really not corpses at all, when considered from both biological and legislative perspectives
They are not corpses from the biological perspective because they have all **perfectly functioning** organs; nor corpses from the legislative perspective, which states that *"the corpse is a human body deprived of the cardio-respiratory and cerebral functions."*(2).
It is well-known that our knowledge of the brain functions only covers a bare 10%(4) of their spectrum; therefore art.1 of law 578/93 (of the Italian legislation) stating that *"death is the irreversible cessation of all functions of the entire brain"* is scientifically an absurdity, because it is not possible to declare an unknown function to be "ceased" (3).
Furthermore many Authors (4) have proved, as well as the Harvard Boston Medical School (5), that following brain-death declaration some of the few known brain functions are still present, in opposition to what the law states.

Let's get to the root of the much debated explant-transplantation question.
In 1985 the "Lega Nazionale Contro la Predazione di Organi e la Morte a Cuore Battente", Italian association against organ explant/transplantation and heart beating death, declared "brain death" to be unacceptable and appointed itself to oppose such a conceptual line (6).
"Brain death" is always certified within the first 24 to 48 hours (with very rare exceptions) following the admission of a general cranic traumatic patient with loss of consciousness (Coma) to an Intensive Therapy Dpt. During this period of time no serious and efficacious attempt of finalistic therapy is put into practice.
The therapy is finalistic only when it challenges the pathological process just at the right time. Without suitable therapy a progressive deterioration of the brain cortex begins, so that recovery of the patient becomes very difficult.
In the long run the grey cerebral substance, eager for oxygen, loses its vitality.
Therefore the elective surgical operation must always **urgently** follow, so as to obtain the decompression of the brain. Time is precious in these cases and therefore the operation to relieve pressure on the brain should be reintroduced as a proper and accepted practice in minor hospitals providing first patient reception. In fact, in past times, the surgeon of minor hospitals had the knowledge and preparation to perform these brain decompressive operations, and he was meant to carry them out.
In present times, for the purpose of increasing the explants-transplantation rate, these patients are moved along to farther away major hospitals, so that the favourable period for their recovery is dramatically shortened. Even though in so acting the **organs are saved at all costs.**

The finalistic therapy is hardly ever put into practice in the appointed explants-transplantations major hospitals, because the neuro-surgeons, pressed by their quest for the organs, are aware that in order to **“save the patient at all costs”** they may risk to lose him during the surgical operation or the postoperative course, this leading to the concomitant loss of his organs.
For “efficacious finalistic therapy” we mean the enaction of a few surgical operations: ventriculostomy, extra- and sub-dural drainages and, if necessary, craniotomy for extra-dural hematoma; these have to be **urgently** performed, if possible within the first 60 to120 minutes since accident occurrence, to the finalistic aim of achieving the decompression of the brain (7).
It is useful to report that an aspiration of few cc. of hemorragic fluid and of the ventriculo-cerebrospinal fluid may be sufficient to obtain brain decompression with the recovery of consciousness and disappearance of the coma. The administration of anti-edematous substances and diuretics and controlled brain hypothermia (8) complete the active **urgent** treatment.
A subject affected by a serious cranial trauma always has an endocranial haemorrhagic collection (small hematoma) or infiltration, not serious in case of the fracture / dislocation of the first two cervical vertebrae (because of the thinness of the laminar bones) (9). This may become on the contrary a serious hematic endocranial collection (big hematoma) in the presence of basilar skull fracture, involving the two petrous rocks that are very vascularized bones (10).
Notoriously this type of fracture is very easy to diagnose even before any radiological check, for the presence of mono- or bilateral otorrhagia (presence of blood in the auricle).

This haemorragic collection (hematoma) leads to compression of the brain and particularly to the compression of the cerebral cortex stratum (about 1 cm. thick) which is in close contact with the indeformable bony structure of the cranium. The compression of the cortical stratum, with its sensorial and motor centers as well as with its speech center, all contributing to consciousness formation, causes the collapse of the “Unified synaptic channel” (USC) (11), a structure that as a labyrinthine network multiplies itself among billions of neurons. During such collapse the consciousness disappears. The patient enters in the state of coma, more or less profound and severe ***according to the extent of the compression***.

The same attention and timeliness obviously apply in case of the extradural haemorragic pathology (fracture or severe contusion of the frontal-parietal bones). These patients have a typical two times rhythm; the patient falls, gets up again, a small arteriole or cortical/meningeal capillary tears and starts bleeding; within a variable amount of time the haematoma develops and the patient a few hours later enters in the state of coma, **when the hematic collection causes a cerebral cortex compression**.
Whether the patient is admitted to a major hospital at once, or only later, after having lost precious time in a minor hospital, in both cases the pathology of compression gets worse within 2 or 3 hours after the trauma.
The appointed head physicians decide to forsake the surgical therapy directed to **save the patient**. To perform the operation would lead to the loss of organs at any rate, should their attempts be successful (recovery) or unsuccessful (death), because in both cases the organs would follow the destiny of the patient.

The relatives of the patient are reassured and silenced with the ritual sentence “we will try our utmost to save him”, which is a conscious lie because the physicians well know that by renouncing to any decompressive surgical operation the patient is doomed.
The declaration of “brain death” conceals any malpractice and by its means the neurosurgeons, the medical examiners and the anesthetists are allowed to avoid any surgical operation and still be under cover, since **to save organs at all costs** is to be lined up with the State’s philosophy.
Such a perverse commandment **overrules the principle to save the patient at all costs**, the true commandment rooted in the history of medicine.

If the comatose patient is admitted to the hospital with spontaneous respiration this means that the respiratory centres of his brain stem are not damaged and therefore the patient should not be undergoing an endotracheal intubation, if not for surgical operating necessity. Generally, however,

when the patient arrives he has already been automatically intubated and ventilated, regardless of effective need. Since that moment onwards his conditions are evaluated via his reflex responses to stimuli, the electroencephalographic examination and the apnea test (ventilation is stopped without weaning, waiting for the return of spontaneous respiratory activity); the latter being repeated more than once in succession, in order to establish the depth of the coma as well as the attainment of the conditions required for the declaration of so-called “brain death” on the basis of State protocols. This test is meant to sample the reactivity of brain respiratory centres to CO_2 (carbon dioxide, accumulated in the blood after the respiratory failure). But after a respiratory failure a diminution of the level of oxygen in the blood (anoxia) is provoked, which, especially if repeated, can irreversibly worsen the already critical neurological conditions of the cranic traumatic patient (12).
On this subject we must remember a general law of Physiology, stating that when any organ, system, tissue or even single cell is substituted in its function, it progressively ceases to perform such a function, up to its atrophy.
It is a well-known law, the application of which we find in the methodology of intubation with automatic ventilation. Well-known it is to the anesthetists, who in order to awaken their patients use the method of “continous and progressive weaning”, which on the contrary is not employed during the apnea test described above.

At the end, the prescribed medical commission is summoned, which decrees, without the possibility of any conscious objection, a pathological condition that is declared to be irreversible, in view of its correspondance to the criteria imposed by the law.
All this is due to the absence of urgent therapy. ***This declaration consequently represents a “death sentence” in itself,*** announced and put into action after a ridiculously short observation period of 6 hours, sending the patient at the mercy of the organs’ explant procedure.

The explant is performed on a patient that reacts to the operatory trauma with movements of the limbs and of the trunk, showing a clear response to surgical incision at the time of organ removal, with an average increase of 31 mm.Hg in his systolic blood pressure and an increased heart rate of 23 beats/min (5). These reactions are inconsistent with the cessation of all brain functions and confirm its vitality, which is furthermore indirectly established by the common practice of preventively administering curarizing and anesthetic drugs to the patient. Death, in the common everyday sense of the word, effectively occurs by the organs’ explant itself.

The Will to save the organs at all costs kills the Will to save the patient at all costs and so the fundamental concept of the medical profession *primum non nocere* is sadly neglected.

It is time to give back to the physicians the right/duty to care according to science and consciousness, without enforcing upon them the limits ordered by the State and by the vertices of sanitary power, which indiscriminately apply the fiction of “stem brain death” criterion(4).

It is time to review drastically the legislation and to give voice to a patient that cannot speak, but launches a message ”Why don’t you try and cure me?”
Someone should be found who could listen to him in the end!

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NOTES

1. The “brain death” appears on the American medical scene in 1968, when after the first heart transplantation (Barnard 1967-Cape Town), the Harvard Medical School fixed the new criteria for the definition of the “brain death” on the alive subjects in “coma supposed irreversible,” for the explants-transplants justification.
2. Cadaver ‘s definition as by Italian Act n.24 of the 24.06.93 of the D.P.R.285/90
3. Redefinition of Death (USA 1968-Italy L.578/93, DM. 582/94)
   With the word *death* artfully joins with the alive ventilated patient declared in “brain death” (according to the State protocol) and the traditional dead in cardio-circulatory arrest. Once the *dead* was always a ”cadaver”, at the present time the so called “cerebral dead” is not a cadaver.
4. Evans D.W.,MD, Consultant Cardiologist at Papworth Hospital, and Hill D.J. MA FFARCS Consultant Anaesthesist at Addenbrooke’s Hospital *“The brain stems of organ donors are not dead”*.Catholic Medical Quarterly, vol.XL n.3 - Agosto 1989.
   Molinari Gf. MD, *“The NINCDS collaborative study of brain death”* n. 81-2286 Bethesda National Institute of Health 1980. In 503 cases study Molinari reported that it was not possible to verify that a diagnosis (brain death) made prior cardiac arrest would invariably correlate with a diffusely destroyed brain.
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   Singer P., President Ass. Internazionale Bioetica, 2° Congresso Intern. sulla “morte cerebrale”, Cuba 1996 *“La morte cerebrale è una finzione”*, act edited by Calisto Machaco Institute of Neurology and Neurosurgery.
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   Barrow J.D., *“The constants of nature”* Mondadori 2003 - pag. 114 “..la stima moderna del numero delle connessioni elettriche che il cervello potrebbe contenere si aggira ad un totale di $10^{70.000.000.000}$ di possibili connessioni...”.
5. Truog R.D. and Fackler J., Dept. of Anaesthesia Harvard Medical School *“Rethinking brain death”*, Critical care medicine, vol.20, n.12,1992
6. La “Lega Nazionale Contro la Predazione di Organi e la Morte a Cuore Battente” started in 1985 a Bergamo after the first heart transplantation inItaly, promoted by AEDfemminismo (Associazione Educazione Demografica-antimedicalizzazione) founded in 1970 by Nerina Negrello. The Lega Nazionale has been developing as an aggregation of free citizens and heterogeneous cultural associations. It is active in cultural, scientific, legal, legislative, informative sphere. Two Hearings by the Parliament in 1992 (Bondì M., Baldissera F., Penso G., Romeo N., Evans D.W., Hill D.J.) and 1998 (Bertolini G., Negrello N., Robbiati M.L., Sonnino R.). Association of “NON donor” who diffuses the “Carta-vita/dichiarazione autografa” a document for written opposition to “brain death” and organs /tissues explantation.
7. Barton R. e Cerra F. Department of Surgery University Utah, University Minnesota, *Il trattamento iniziale del paziente tramatizzato – gli interventi da effettuare nei primi 60 minuti,* Stampa Medica, 506 (5) 15 marzo 1991.
8. Yoshio Watanabe, Emeritus of Medicine *“Once again on Cardiac Transplantation: Flaws In The Logic Of The Proponents.”* JPN Heart J. Sept 1997.
   Hayashi N. , Department of Emergency&Critical Care Medicine, Nihon University *“Brain hypothermia terapy”*, Jpn Med J. No 3767, July 6, 1996.
9. The fracture/dislocation of the two first cervical vertebrae if determines a lesion of bulbal/truncal centers produces the sudden death.
10. Koonsman M. e altri., Department of Surgery -Methodist Medical Center – Dallas,*“How much monitoring is needed for basilar skull fractures?”* Congress April 26-29 1992. The Americam Journal of Surgery vol.164,november 1992.
11. Bondì M. e Bondì M., Riv. Biol. / Biology Forum *“The role of synaptic junctions in the identification of human consciousness”* (1998) pag. 329-334.
    Bondì M. e Bondì M., *“... interpretation of the patho genesis of the coma”*. ECPD Brain consciousness international-symposium 22-23 settembre 1997 pag. 201-204 – Belgrade Jugoslave.
12. Coimbra Cicero. - Medico Neurologista , Prof. Adjunto o Departamento de Neurologia e Neurocirurgia Un. Federal de São Paulo., *“ Apnèia na Morte Encefalica”*, luglio 2001.*“Implications of ischemic penumbra for the diagnosis of brain death: Apnea testing may induce rather than diagnose death”* 2.7.2001
    Coimbra Celso, avvocato, has presented (1.3.04) to the Federal Ministry the denounce : *“Omicidio como pratica medica determinada pelos gestores do Conselho Federal de Medicina”* a detailed denounce of murders through practice of medical profession, carrying out the compulsory apnoea test for the so called “ascertainment” of “ brain death”.