Vital Organ Transplantation and "Brain Death"
A Re-Examination of the Basic Issues by Dr. Paul A. Byrne

Since the founding of the IFGR/MF in 1978, the Michael Fund Newsletter has covered many life-death issues, particularly those related to the field of genetics including eugenic abortion, prenatal diagnosis and genetic counseling. In this issue of our newsletter, we examine some important aspects of vital organ transplantation with the distinguished physician and pro-life advocate, Dr. Paul Byrne. Editor, Randy Engel

Editor: Dr. Byrne, how would you describe the body of a human being?

Dr. Byrne: A human person on earth is composed of body and soul. God creates the person. Biologically speaking, the body is composed of cells, tissues, organs and eleven systems, including three major vital systems. No one organ or system controls all other organs and systems. Interdependent functioning of organs and systems maintains unity, homeostasis, immune defenses, growth, healing and exchange with environment, e.g., oxygen and carbon dioxide. Life on earth is a continuum from its conception to its natural end. The natural end (true death) occurs when the soul separates from the body.

Editor: Most adults and children, even if they are not physicians, recognize signs of life, don't they?

Dr. Byrne: Yes, of course. The vital signs of a living human being include temperature, pulse, blood pressure and respiration. Physicians, nurses and paramedics listen to the beating heart with a stethoscope. Patients in intensive care units have monitors to demonstrate the beating heart, blood pressure, respiration and oxygen in the blood.

Editor: What about the signs of death?

Dr. Byrne: Throughout the ages, death has been and is a negative, an absence – the state of the body without life. The soul has left the body and decomposition has begun. After death what is left on earth is a corpse. The remains are empty, cold, blue, rigid and unresponsive to all stimuli. There is no heartbeat, pulse or blood pressure. The patient has stopped breathing. There is poor color of the skin, nails, and mucous membranes. Ventilation will not restore respiration in a corpse. A pacemaker can send a signal but it cannot initiate the heartbeat in the corpse. Healing never occurs in a patient that is truly dead.

Editor: When we speak of vital organs, what organs are we talking about?

Dr. Byrne: Vital organs (from the Latin vita, meaning life) include the heart, liver, lungs, kidneys and pancreas. In order to be suitable for transplant, they need to be removed from the donor before respiration and circulation cease. Otherwise, these organs are not suitable, since damage to the organs occurs within a brief time after circulation of blood with oxygen stops. Removing vital organs from a living person prior to cessation of circulation and respiration will cause the donor's death.

Editor: Are there some vital organs which can be removed without causing the death of the donor?

Dr. Byrne: Yes. For example, one of two kidneys, a lobe of a liver, or a lobe of a lung. The donors must be informed that removal of these organs decreases function of the donor. Unpaired vital organs however, like the heart or whole liver, cannot be removed without killing the donor.

Editor: Since vital organs taken from a dead person are of no use, and taking the heart of a living person will kill that person, how is vital organ donation now possible?

Dr. Byrne: That's where "brain death" comes in. Prior to 1968, a person was declared dead only when his or her breathing and heart stopped for a sufficient period of time. Declaring "brain death" made the heart and other vital organs suitable for transplantation. Vital organs must be taken from a living body; removing vital organs will cause death.

Editor: I still recall the announcement of the first official heart transplant by Dr. Christian Barnard in Cape Town, South Africa in 1967. How was it possible for surgeons to overcome the obvious legal, moral and ethical obstacles of harvesting vital organs for transplant from a living human being?

Dr. Byrne: By declaring "brain death" as death.

Editor: You mean by replacing the traditional criteria for declaring death with a new criterion known as "brain death"?

Dr. Byrne: Yes. In 1968, an ad hoc committee was formed at Harvard University in Boston for the purpose of redefining death so that vital organs could be taken from persons declared "brain dead," but who in fact, were not dead. Note that "brain death" did not originate or develop by way of application of the scientific method. The Harvard Committee did not determine if irreversible coma was an appropriate criterion for death. Rather, its mission was to see that it was established as a new criterion for death. In short, the report was made to fit the already arrived at conclusions.

Editor: Does this mean that a person who is in a cerebral coma or needs a ventilator to support breathing could be declared "brain dead"?

Dr. Byrne: Yes.

Editor: Even if his heart is pumping and the lungs are oxygenating blood?

Dr. Byrne: Yes. You see, vital organs need to be fresh and undamaged for transplantation. For example, once breathing and circulation ceases, in five minutes or less, the heart is so damaged that it is not suitable for transplantation. The sense of urgency is real. After all, who would want to receive a damaged heart?

Editor: Did the Harvard criterion of “brain death” lead to changes in state and federal laws?

Dr. Byrne: Indeed. Between 1968 and 1978, more than thirty different sets of criteria for “brain death” were adopted in the United States and elsewhere. Many more have been published since then. This means that a person can be declared "brain dead" by one set of criteria, but alive by another or perhaps all the others. Every set includes the apnea test. This involves taking the ventilator away for up to ten minutes to observe if the patient can demonstrate that he/she can breathe on his/her own. The patient always gets worse with this test. Seldom, if ever, is the patient or the relatives informed ahead of time what will happen during the test. If the patient does not breathe on his/her own, this becomes the signal not to stop the ventilator, but to continue the ventilator until the recipient/s is, or are, ready to receive the organs. After the organs are excised, the “donor” is truly dead.

Editor: What about the Uniform Determination of Death Act (UDDA)?

Dr. Byrne: According to the UDDA, death may be declared when a person has sustained either “irreversible cessation of circulatory and respiratory functions” or “irreversible cessation of all functions of the entire brain, including the brain stem.” Since then, all 50 states consider cessation of brain functioning as death.

Editor: How does the body of a truly dead person compare with the body of a person declared “brain dead”?

Dr. Byrne: The body of a truly dead person is characterized in terms of dissolution, destruction, disintegration and putrefaction. There is an absence of vital body functions and the destruction of the organs of the vital systems. As I have already noted, the dead body is cold, stiff and unresponsive to all stimuli.

Editor: What about the body of a human being declared to be “brain dead”?

Dr. Byrne: In this case, the body is warm and flexible. There is a beating heart, normal color, temperature, and blood pressure. Most functions continue, including digestion, excretion, and maintenance of fluid balance with normal urine output. There will often be a response to surgical incisions. Given a long enough period of observation, someone declared “brain dead” will show healing and growth, and will go through puberty if they are a child.

Editor: Dr. Byrne, you mentioned that “brain dead” people will often respond to surgical incisions. Is this referred to as “the Lazarus effect?”

Dr. Byrne: Yes. That is why during the excision of vital organs, doctors find the need to use anesthesia and paralyzing drugs to control muscle spasms, blood pressure and heart rate changes, and other bodily protective mechanisms common in living patients. In normal medical practice, a patient’s reaction to a surgical incision will indicate to the anesthesiologist that the anesthetic is too light. This increase in heart rate and blood

pressure are reactions to pain. Anesthetics are used to take away pain. Anesthesiologists in Great Britain require the administration of anesthetic to take organs. A corpse does not feel pain.

Editor: I know that there have been instances where young pregnant women have sustained serious head injuries, declared "brain dead," and have given birth to a live child.

Dr. Byrne: That is true. With careful management, these "brain dead" women have delivered a live baby. In the longest recorded instance, the child was carried for 107 days before delivery.

Editor: Are there other uses for "brain dead" patients besides being the source of fresh vital organs?

Dr. Byrne: Legally, "brain dead" patients are considered corpses or cadavers, and are called such by organ retrieval networks. These "corpses" can be used for teaching purposes and to try out new medical procedures. Yet these same "corpses" are carrying unborn children to successful delivery. Certainly this is extraordinary behavior by a "cadaver!"

Editor: What if a potential organ donor does not meet the criteria for "brain death," but has sustained certain injuries or has an illness suggesting that death will soon occur?

Dr. Byrne: Such cases have brought about the development of a what is called "non heart-beating donation" (NHBD), more recently labeled "donation by cardiac death" (DCD)–in which treatments considered extraordinary means, such as mechanical ventilation, are discontinued and cause the patient to become pulseless. As soon as circulation stops, death is declared.

Editor: Then what?

Dr. Byrne: This stopping of life supporting treatments is done in the operating room. After a few minutes–the time varies in different institutions–procedures to take vital organs begins.

Editor: But how can this be accomplished if the person declared to be dead, is truly dead?

Dr. Byrne: It can't.

Editor: What about insurance coverage for "brain dead" patients?

Dr. Byrne: Hospitals allow them to occupy a bed and insurance companies cover expenses as they do for other living patients. If the patients' organs are suitable for transplantation, any transfer of the patients to another hospital is covered by insurance.

Insurance also covers the cost of life support, blood transfusions, antibiotics and other medications needed to maintain organs in a healthy state. This also applies to "brain dead" patients to be used in medical teaching facilities.

Editor: I know that the federal government has taken an active role in promoting so-called "living wills." Has it also played a role in promoting vital organ donations?

Dr. Byrne: The federal government has, for reasons that are unclear, been deeply involved in promoting vital organ transplantation. For example, a federal mandate issued in 1998 states that physicians, nurses, chaplains, and other health care workers may not speak to a family of a potential organ donor without first obtaining approval from the regional organ retrieval system. If the potential for transplantation exists, a trained "designated requester" visits with the family of the patient first, including families that adamantly oppose organ donation. If someone at the hospital speaks to the family of the patient first, the hospital risks losing its accreditation and possibly federal funding.

Editor: Why the "designated requester"?

Dr. Byrne: That's because studies show that these specialists have a greater success obtaining permission for organ donations from grieving family members. They are trained to "sell" the concept of organ donation, using emotionally-laden phrases such as "giving the gift of life," "your loved one's heart will live on in someone else," and other similar platitudes, all empty of true meaning. Don't forget that the donation and transplant industry is a multi- billion dollar enterprise. In 1996, Forbes Magazine ran an informative series on this issue, but as a rule it is difficult, if not impossible, to obtain solid financial data. One thing, however, is clear: donor families do not receive any monetary benefit from their "gift of life."

Editor: There appears to be a strong utilitarian aspect to vital organ transplantation.

Dr. Byrne: That is because the philosophy that inspires the practice is based on the error that man is an end to himself, and the sole maker with supreme control of his own destiny. Slavery bought, sold and treated enslaved persons as chattel. The human transplantation industry and the "bioethics" groups that promote vital organ transplantation also consider human beings to be chattel, that is, they can be used as a source of organs for transplantation. This utilitarian ethic should be rejected. "Brain death" and all forms of imposed death are contrary to the Natural Moral Order and against God's Ordinance "Thou shall not kill."

Editor: It is obvious that organ donation is a very serious matter – literally a matter of life and death for the potential donor and the family of a potential donor, and that everyone ought to be implicitly and explicitly informed about the true nature of so-called "brain death" and vital organ transplantation.

Would you review for our readers some of the questions they should ask themselves before signing an organ donor card or giving permission for a loved one to be declared "brain dead" in anticipation of organ transplantation?

Dr. Byrne: If there is any question in the mind of your readers as to the fact that "brain death" is not true death, perhaps they may want to ask themselves the following questions regarding "brain death" and vital organ transplantation:

· Why can health insurance cover intensive care costs on "bread dead" patients?

· Why do "brain dead" patients often receive intravenous fluids, antibiotics, ventilator care, and other life support measures?

· Is it right and just for physicians and "designated requesters" to tell families that their "brain dead" loved one is dead when she or he is not dead?

· How can "brain dead" patients have normal body functions, including vital signs, if they are really dead?

· How can a "brain-dead" pregnant mother deliver a normal, healthy infant?

· Why does a ventilator work on someone declared "brain dead," but not on a corpse?

· Why is it wrong to carry out the burial or cremation of a "brain-dead" person?

· Are persons who have been declared "brain dead" truly dead?

· If "brain-dead" persons are not truly dead, are they alive?

Editor: Thank you on behalf of The Michael Fund for providing this valuable information to our readership?

Dr. Byrne: Thank you for this opportunity to inform your readers about this vital issue of vital organ transplantation. If they don't remember every thing that I have said, I hope that they will remember this one point: "brain death" is not true death. Instead of signing a donor organ card, I would encourage everyone to obtain a Life Support Directive. A free copy of this document is available from Citizens

United Resisting Euthanasia at: cureltd@verizon.net or write C.U.R.E, 303 Truman Street, Berkeley Springs, WV 25411.

Dr. Paul A. Byrne is a neonatologist and a Clinical Professor of Pediatrics. He is a member of the Fellowship of Catholic Scholars and past-President of the Catholic Medical Association. He is the producer of the film Continuum of Life and the author of Life, Life Support and Death, Beyond Brain Death, and Brain Death is Not Death. Dr.

Byrne has presented testimony on life-death issues to eight state legislatures beginning in 1967. He opposed Dr. Jack Kevorkian on the television program *Crossfire*. and has appeared on *Good Morning America* and the British Broadcasting Corporation (BBC). The International Foundation for Genetic Research, popularly known as The Michael Fund, is a U.S.-based pro-life genetic research agency specializing in Down syndrome research. Please visit us at www.michaelfund.org.