



Neurologist exposes 'brain death' myth behind multi- billion-dollar

organ transplant industry

Diane Montagna, Wed Jun 5, 2019 - 5:47 pm EST

ROME, June 5, 2019 ([LifeSiteNews](#)) — A respected Brazilian neurologist is seeking to blow the lid off the “brain death” myth, saying it is being perpetuated to supply an international multi-billion-dollar transplant industry.

Doctor Cicero G. Coimbra, MD PhD, a neurologist and professor of neuroscience at the Federal University of São Paulo, Brazil, has also said recovery for comatose patients is often possible, but a tightly controlled medical establishment is not giving doctors and medical students the facts they need to “do the best they can” for their patients.

LifeSite sat down with Dr. Coimbra for an in-depth interview in Rome, during a May 20-21 conference on [“Brain Death”: A Medicolegal Construct: Scientific & Philosophical Evidence](#) (<https://www.jahlf.org/general-assembly-2019/>), sponsored by the [John Paul Academy for Human Life and Family](#) (<https://www.jahlf.org/>).

In this interview (read full text below), Dr. Coimbra explains that the term “brain death” was coined in the 1960s, after the first successful human heart transplant “triggered a demand for transplantable vital organs to be harvested from patients” who were considered to be “hopelessly comatose” according to medical knowledge at that time.

There was “no preliminary scientific research” on the brain-death concept before the name was used, he said. But calling these patients “dead” enabled the medical community to overcome all of the legal hurdles associated with removing vital organs from these comatose patients.

Their main mistake, Dr. Coimbra argues, was to consider these patients “irreversibly” brain damaged.

By the 1980s, when organ transplants were performed around the world, medical researchers experimenting on animals discovered that when blood flow to the brain is reduced from the normal range to just 20-50 percent, the brain would “fall silent” — but was neither “dead” nor “irreversibly damaged.” By the end of the 1990s, this phenomenon — called “ischemic penumbra” — was demonstrated in humans, shattering the “brain death” myth.

The brain is silent but not dead, he said.

“Why is the ‘brain death’ theory still so prevalent, and what are students in medical school being taught about this?” LifeSite asked Dr. Coimbra.

The Brazilian neurologist explained that while medical students might hear about this if “information is provided to the general public,” they will not learn it in medical school.

“In medical schools, these concepts that I am telling you about — although they are published — are not available in medical

textbooks. They are not available in medical meetings. In medical conferences you cannot find them,” he said, adding that information is being withheld to supply the organ donation industry.

If you speak to doctors one-on-one, they will often tell you they agree, Dr. Coimbra said, but “they don’t want to mess with the transplant system,” which has one of the most “well controlled systems” of information sharing in the world.

“The transplant system is a wealthy system; it is a powerful system,” Dr. Coimbra said. “They are everywhere in the medical community. They are in medical councils and medical academies; they are everywhere ... Politically, they are very powerful.”

“In the United States alone, in 2016 the transplant system involved business to the tune of approximately 25 billion dollars,” he noted. “By 2025, it is expected to reach 51 billion dollars per year.”

It is “big business,” he said.

Dr. Coimbra continued:

The brilliant idea of the transplant system was to call what they thought to be irreversible brain damage “brain death.” Because whenever you say someone is against “brain death,” you think: “How can someone possibly be...against death? They don’t believe in death?” But “death” is just a word that was given to a “hopelessly comatose” patient — but they were “hopelessly comatose” at the end of the 60s, not now.

“In a very large number of those patients, they have no damage at all — no brain damage at all — they just have a silent brain,” he added.

To compound the problem, Dr. Coimbra said the standard test used for screening “brain death” — called the “apnea test” — can actually induce irreversible brain damage to an already comatose patient, by reducing the blood and oxygen to the brain for 10 minutes.

Dr. Coimbra said he has seen firsthand that there is hope for patients who have been labeled “brain dead.” If doctors would simply replace three essential (thyroid and adrenal) hormones, “the normal circulation to the brain would be restored,” he explained. But when these hormones are not replaced, the patient progresses “into a disaster.”

The Brazilian neurologist again noted that doctors and medical students are not taught this:

They know what is in the neurology textbook of medicine ... They know what’s there, and this is not there. The importance of replacing thyroid hormone is not discussed in meetings related to brain injuries, and how to treat brain injuries. Not one single intensive care unit in the world replaces thyroid hormones — not a single one that I know of.

To illustrate how much the “brain death” myth has gripped the minds of the medical community, Dr. Coimbra tells the story of a 15-year old girl who began to show signs of brain activity once he administered the necessary hormones. Seeing notes of progress Dr. Coimbra had made in the girl’s medical chart, a doctor on call in the ICU that night wrote: “Once a patient is declared ‘brain dead,’ the patient is dead. It doesn’t matter if later on the patient no longer fulfills the criteria for ‘brain death.’ The patient is legally dead, because it was once diagnosed as ‘brain dead.’”

In the end, Dr. Coimbra said it all comes down to the duty of doctors to honor their sacred oath to “do no harm” and to “do the best they can” for the health and wellbeing of their patient.

Here is our interview with Dr. Cicero Coimbra, MD, PhD, followed by a [video of his talk at the recent “brain death” conference](https://www.youtube.com/watch?v=2ISpsvW4H68) (<https://www.youtube.com/watch?v=2ISpsvW4H68>) in Rome.

Dr. Coimbra, why is “brain death” a myth?

By the end of the 1960s, the first human heart transplant performed by the surgeon Christiaan Barnard in South Africa triggered a demand for transplantable single vital organs to be harvested from those patients considered to be “hopelessly comatose.” It was the common understanding that, by using all possible techniques and knowledge available at that time, those patients could not be restored to a normal life and would rather eventually evolve to cardiac arrest within a matter of days; they would not recover consciousness. An ad hoc committee at Harvard Medical School decided to call their clinical condition “brain death,” so that they could remove vital organs maintained viable due to sustained heart beating (maintained supply of oxygenated blood) and use those organs to improve the health [of] other people — patients, for instance, who had liver failure, kidney failure, or end-stage heart failure. These people would benefit from having the organs from patients who were “hopelessly comatose.”

Calling these patients “dead” enabled the ad hoc committee to overcome all legal problems related to removing vital organs from comatose patients that could not recover according to the concepts and medical scientific knowledge that we had available by that time, i.e. by the end of the 1960s.

In order to transplant organs, they had to be removed from someone while they are still alive, while the heart is still beating?

Yes, they removed them from a comatose patient. But they thought it would not be possible to recover those patients, because they did not have the technology and knowledge to recover them.

The main mistake was to consider those patients “irreversibly” brain damaged, but their brain damage was considered irreversible due to the limited knowledge that they had at that time. Later on, as time went by, new knowledge and neurological scientific achievements offered other ideas about what was really going on in these patients. For instance, by the end of the 1960s — when the concept of “brain death” was introduced into medicine — doctors believed that, when there were no signs of brain activity that could be detected by neurological examination, the only possible reason would be the absence of blood circulation in the brain. And because the absence of brain circulation would destroy the brain within minutes, they decided to call it “brain death.”

The problem is that in the 1980s everything started changing. The practice of transplanting vital organs had already spread across the world, but already by 1984 or 1985 experiments carried out in animals — in rodents — demonstrated that when you decrease blood flow to the brain to only 50 percent of the normal range, the brain falls silent. This is because there is not enough energy to sustain what we call “synaptic activity.” Synapsis is the site where one neuron communicates with another neuron. Synaptic activity, which is the release of neurotransmission at the synaptic site, was no longer possible in these brains, because the brain blood flow

was 50 percent of the normal range, and that would not provide enough energy for synaptic activity, for neurons to communicate with one another. So, the brain was silent, but the neurons would not die just because the blood flow was reduced to 50 percent.

So, the brain was silent but not dead...

Yes, silent but no neuronal death — no “brain death.” Necrosis, i.e. the process of neuronal death, is a process that takes several hours and is triggered when the blood flow is lower than 20 percent of the normal range.

This interval (approximately between 20 percent and 50 percent of the normal level of circulation) is now known as the “penumbra zone.” It was initially described in situations where there is an obstructed artery that supplies part of the brain. In the peripheral area of this so-called “ischemic” part of the brain, there was a collateral flow of blood supply between 20 and 50 percent of the normal flow, as demonstrated in animals. If you could recirculate that artery, you would save the peripheral area because it was only silent. It was not necrotic; it was not destroyed.

It is quite clear that when you have a patient with head trauma, and the brain is swelling, at some point the arteries that supply blood to the brain start being compressed, because the brain size is increasing within the intracranial space. The intracranial space is protected by bones, and bones cannot expand to accommodate the increase in brain volume. So, if the size of the brain increases as a result of what we know as “brain edema” or “brain swelling,” then the vessels are progressively compressed, and the blood flow to the whole brain decreases proportionally to increases in intracranial pressure. At some point, you will reach the level of a 50 percent decrease as compared to normal range. At this point the whole brain is silent — not a part of it but all of it is silent — but it is still recoverable. It is not dead; it is alive. And that situation was unknown at the end of the 1960s, when the concept of “brain death” was introduced into medicine.

So, it is clear that some of those patients are actually alive. What do I mean by alive? The brain was not destroyed; it was only silent. And the transplantation system has been taking organs from patients who had brain tissue that theoretically could be recovered. That brain tissue is not destroyed.

To me, it was quite clear by the end of the 1990s when the phenomenon of “ischemic penumbra” — a silent brain but no brain destruction — was demonstrated in humans, not only in rodents, that this situation could be called “global ischemic penumbra.”

The problem is that one of the tests used to diagnose “brain death” — called the “apnea test” — involves switching off the respirator. You disconnect the respirator for 10 minutes. When you do that, the high level of carbon dioxide increases sharply. This in turn further increases intracranial pressure and may decrease arterial pressure. So, you increase the compression on the brain vessels and you decrease the pressure within the brain vessels during the apnea test.

What was the purpose of the apnea test?

The aim of the apnea test is to demonstrate that the patient cannot breathe on his own.

In any culture in the world, it would be unacceptable to say that someone who is breathing is dead. Spontaneous breathing in any culture means life. So, for instance, when a baby is born, and it never breathes, you say that it was born dead. But if the lungs expanded at least once, for legal purposes, even if the baby immediately dies, you say that the baby is alive. The question of

whether the baby is alive or dead when the baby is born has considerable legal consequences. No one in any culture of the world — Indian culture or Western culture, etc. — would accept anyone to be dead if that person is capable of breathing on his own. So, the purpose of the apnea test is to demonstrate that the patient cannot breathe on his own and can be regarded as dead.

But imagine for a moment: the respirator is disconnected from the lungs for 10 minutes. In order to breathe on your own, you need your respiratory centers in your brain to be working. They control the diaphragm and the respiratory muscles in general. If you switch off the respirator, and there is no breathing for 10 minutes, they say: “Ok, you see, this is one more piece of evidence that the patient is dead, because he cannot breathe on his own.” The apnea test is considered the fundamental test to diagnose “brain death.” No medical doctor anywhere in the world would diagnose “brain death” without doing this test. So, whenever you hear that a certain patient has been diagnosed as “brain dead,” you know that the apnea test has been performed.

Why isn't the apnea test legitimate?

It's not legitimate. Actually, it disrupts the most basic concepts of medicine. For instance, imagine if I prevent you from breathing for 10 minutes, what will happen? You will die.

But in this case, a respirator is helping the person to breathe.

Yes, right. The respirator is helping the person to breathe. You're correct, no problem about that. The issue is: you are testing the vitality of the respiratory centers. But what will happen to the respiratory centers in a silent brain if you induce a test that decreases the blood flow to the respiratory centers? The respiratory centers were already silent, because they need synaptic function to work. If the blood flow is within the penumbra zone — between 20 and 50 percent — the respiratory centers cannot work, not because they are irreversibly damaged but because they are silent. You would not diagnose this as “brain death.” You will not differentiate the condition of global ischemic penumbra from irreversible brain damage by testing the respiratory function.

You can actually destroy the respiratory centers — as you can damage all parts of the brain — by further reducing the blood flow during the apnea test. Forty percent of the patients who are submitted to the apnea test have a major drop in their blood flow, in their blood pressure. Blood pressure is the pressure that is within the arteries; it's the pressure that provides the driving force to maintain circulation in the brain. So, when you perform the apnea test, you may actually induce irreversible damage to the brain when you were only supposed to diagnose irreversible brain damage.

That would seem to go against the Hippocratic oath? You are harming the patient in order to apparently test whether a silent brain is dead.

The silent brain is not dead. You induce irreversible damage to the respiratory centers and to the whole brain just by performing the apnea test. So, as you said, they are not respecting the Hippocratic oath, because the most basic concept of medical practice is what you just said: First, “do no harm.” And the second is, “do the best you can.” So, neither of these basic concepts of the Hippocratic oath are being respected in this situation.

If this research has been done in humans as well as in rodents, why is the “brain death” theory still prevalent? And what are students in medical school being taught about this? Would they hear about this latest research?

Well they may hear about it, if you provide information to the general public as you were trying to do. But in medical schools these concepts that I am telling you about — although they are published — are not available in medical textbooks. They are not available in medical meetings. In medical conferences you cannot find them.

Nowadays the transmission of information within the medical community in general — not only in this country or that, but worldwide — is probably, or certainly, the most well controlled system of transmitting information, because it is worth billions of dollars per year. If you put information in a textbook, it can redirect the flow of money from one sector to another. It's the most well controlled type of transmitting information in our society that I know of.

Are you saying that, for the sake of the organ donation and organ transplant industry, the general public and medical students are not being given this information?

Yes, I have been trying to talk to the neurological community in my country and in other countries, and the reaction that we see is that some [doctors] will tell you — “Okay, I understand what you are saying, but never tell anyone that I agree with you” — because they don't want to mess with the transplant system. The transplant system is a wealthy system; it is a powerful system. They are everywhere in the medical community. They are in medical councils and medical academies; they are everywhere. They are very powerful. Politically, they are very powerful.

What could happen to a doctor if he tried to go against the system?

Well, maybe what happened to me. I had to fight in court to hold on to my license to work as a doctor for 19 years in Brazil. And that was a long time. So, you understand why some doctors that are aware of what is happening do not want to talk freely about that. They simply do not want to mess with powerful people.

They even control and have an influence in the press. Sometimes it is said, “Oh that doctor is against ‘brain death.’” The brilliant idea of the transplant system was to call what they thought to be irreversible brain damage “brain death.” Because whenever you say someone is against “brain death,” you think: “How can someone possibly be against death? They don't believe in death?” But “death” is just a word that was given to a “hopelessly comatose” patient — but they were “hopelessly comatose” at the end of the 60s, not now.

Now you can understand that, in a very large number of those patients, they have no damage at all — no brain damage at all — they just have a silent brain. And that was confirmed in the middle of the 70s. In the mid 70s, some people from histopathology or pathologist[s] started wondering how a doctor since 1968 (when “brain death” was introduced into medicine) can say that there is necrosis of the whole brain — that there is irreversible damage of the cells in the whole brain, just by doing a neurological examination? Pathologists started wondering what is happening here. They wondered: “How can they possibly use a term like ‘necrosis,’ which is the terminology that only pathologists use when they look at the tissue under the microscope.”

So, they started checking into this. They did histological examinations in patients who were diagnosed as “brain dead” for 48 hours — so time enough for full necrosis to occur. No signs of brain activity, no evidence of blood flow for 48 hours. The whole brain should be necrotic; it's time enough for full necrosis. When they examined those brains — I think the article was published by

1976 — they saw that about 60 percent of those brains had no signs of necrosis at all.

People who were in favor of “brain death” had to defend themselves when these papers were published. They said, “Okay, necrosis in those cases is indicated by such tiny signs that you cannot see it in the microscope. That’s why you cannot see it, but we know it’s there. We know, because there is no possible explanation for absence of blood flow for 48 hours.” Again, when more and more evidence was available to demonstrate that what they had thought in 1968 — which was complete absence of blood flow — was not true, they tried to say something else or invent something else in order to explain it — even as a hypothesis.

You saw that in this conference [on [“Brain Death”: A Medicolegal Construct: Scientific & Philosophical Evidence](#)] — it was said several times — that when the practice of “brain death” was introduced into medicine, there were no scientific papers to support it, no scientific research. It was simply a concept: “Ok, we believe that those patients have no blood flow, because they have such a severe edema that the blood vessels are completely compressed. There’s no blood flow. There is no way that the brain could survive after a few hours under no blood flow. So, we will call it ‘brain death’ because that’s what we believe is going on.”

But as I told you, and as you heard from several speakers, there was no preliminary scientific research on the concept of “brain death” to support the concept of “brain death.”

While they claimed that the brain was “dead,” what was going on in the body? The heart is still beating...

Yes, because if it’s not beating you cannot use vital organs. If there is an arrest in circulation, you have damaged organs that you’re trying to transplant to other people.

Dr. Coimbra, when people hear “brain death,” they think the brain is dead. But as you have explained, the brain is actually silent. When the brain is silent, what is the state of the other organs and systems in the body?

This is a very important question, because one of the parts of the brain that is possibly within the range of ischemic penumbra, between 20 percent and 50 percent of the normal levels of circulation, is the hypothalamus.

The hypothalamus produces several hormones that control other glands in our body. And there are at least three hormones that are very important to our discussion. Because the hypothalamus is also under low levels of circulation, the production of those hormones is decreased.

For instance, one of these hormones is the hormone that releases TSH from the pituitary gland. TSH is “thyroid stimulating hormone.” So, you have the hypothalamus producing TSH-releasing hormone. TSH-releasing hormone induces the production of TSH by the hypophysis [pituitary gland]. The hypophysis releases TSH into the circulation, and then the thyroid gland located in our neck keeps producing thyroid hormone.

Thyroid hormones have an action in the brain. They have actions in all of our organs. One of the most important actions is to prevent fluid from leaking into the tissues. So, when you have a patient who has had a brain trauma, for instance, and that trauma has increased the volume of the brain, and now the blood vessels are compressed, the blood vessels that supply blood to the hypothalamus are also compressed. And then you get into a state that is called “Central hypothyroidism.” In this state, the thyroid

gland decreases the production of thyroid hormones, because the thyroid gland is not receiving enough stimulation from the brain.

So, the lack of thyroid hormones increases brain damage and brain edema, i.e. brain swelling. This is a critical situation, which I could put this way: if you don’t replace thyroid hormone the brain tissue will die, because the brain swelling will progress, progress, and progress up to the point that the blood vessels are fully compressed, and you have no blood flow at all. Then you have irreversible damage to the brain. But when the blood supply to the brain is within the range of “ischemic penumbra” (a silent but not irreversibly damaged brain) or progressing to that situation (progressing into deeper levels of coma — with reduced, but not absent neurological signs of brain activity) you can rescue the brain, just by giving three hormones.

One of the most important ones is the thyroid hormones. If you give the comatose patient thyroid hormones, you will prevent further leakage of liquids from the intravascular space (the space within blood vessels) into the brain tissue. The progress of brain swelling will stop and reverse, the brain vessels will no longer be compressed, you will increase the blood supply to the brain and the patient will start recovering brain functions.

But this situation starts long before the beginning of [the] screening test for “brain death.” We have a scale to measure the level of coma. It’s called the “Glasgow Coma Scale.” A normal person who is fully awake is at level 15 on the Glasgow Coma Scale. When there are no signs of brain activity, you are at level 3. When you reach level 3, you start screening the patient for the diagnosis of “brain death.”

But when the Glasgow Coma Scale is far away from 3 — when it is around 8 or 7 — most if not all patients have low circulating levels of thyroid hormone. By that point the brain edema is now turned into the so-called “brain myxedema,” because the edema is now caused by a lack of enough amounts of thyroid hormones. Therefore, if you start replacing thyroid hormones when a patient of a traumatic brain injury is at the Glasgow levels of 8 or 7 — the patient’s neurological state can improve and even all neurological functions can be normalized. And this is an obligation, this is not something that you say, “Okay, I will leave it like that.” No, you see that something is wrong, and you can save the life of a patient. Hypothyroidism is a lethal disorder; if you don’t treat it patients will die.

It goes back to what you said about the Hippocratic oath. The most basic part is “do not harm” to your patients. But the second part is “do the best you can” to save the life of your patients, to improve their health, to improve the wellbeing of your patient.

So “do your best” and now you’re not following the second aspect of the Hippocratic oath. You should replace thyroid hormones in order to prevent so-called “brain death.”

And is this generally done? Are these three hormones generally given?

No, it’s not done anywhere.

Why not?

This is a question that the medical community should answer. Why are they not following the second principle of the Hippocratic oath in this situation? It’s been published since the 80s.

So they know ... it’s not as though the doctors who are dealing with these patients don’t understand what happens to the thyroid ...

When you say they “know,” I have to say that it’s published, but I would not say that the doctors “know” because they don’t know everything that is published. They know what is in the neurology textbook of medicine, like the neurology textbook. They know what’s there, and this is not there. The importance of replacing thyroid hormone is not discussed in meetings related to brain injuries, and how to treat brain injuries. Not one single intensive care unit in the world replaces thyroid hormones — not a single one that I know of. Because, you know, if you would replace thyroid hormones when the Glasgow Coma Scale is at 7 or 8, probably almost no patient would progress into so-called “brain death.” So, it’s not done — it’s simply not done.

What happens to the brain when these thyroid hormones are not given to the patient?

As the brain swells because thyroid hormones are not replaced, the hypothalamus stops or decreases the production of other hormones that are very important for the survival of the comatose patient.

One of the most important ones is the so-called ACTH. ACTH is a hormone that is produced under the stimulation of the hypothalamus. It is produced by the hypophysis [pituitary gland], and it stimulates the adrenal glands to produce hormones that keep your blood pressure within the normal range.

If you can compose the whole situation in your mind: you have a decreased level of thyroid hormones — that’s why the brain is swelling, that’s why the blood flow is decreased: because blood vessels are being compressed in the intracranial space. The patient is evolving to the so-called...“brain death.” And now, the pressure within the vessels that is necessary to supply blood flow to the brain is also decreasing, because the adrenal glands are not providing enough amounts of what we call “mineralocorticoids” to stabilize the blood pressure. So, the blood pressure within the vessel is going down — the pressure which is necessary to supply blood flow to the brain.

So, you have these two circumstances that co-operate to damage the brain: you have increased intracranial pressure because of lack of thyroid hormones, and you have decreased blood pressure because of low levels of adrenal hormones. And again, because those adrenal hormones are not replaced, the patient — the whole organism — is progressing into a disaster.

You said that three hormones should be given. What is the third?

There is a third hormone that should be given to those patients and it’s also produced by the hypothalamus and the hypophysis. It is called ADH, which stands for “antidiuretic hormone.” It prevents your kidneys from releasing large amounts of fluid that would further decrease the volume within your vessels. The further decrease in pressure within the blood vessels comes from the fact that you don’t have enough volume within your circulatory system to sustain circulation.

This third hormone is the only one that is sometimes given to those patients, because it’s impossible not to identify this situation. If you want to identify the situation when thyroid hormones are low, you have to measure them. If you want to identify a situation where adrenal gland hormones are low, you have to measure them. But you know whether the patient is producing low levels of ADH, you know it because he (she) is eliminating a lot of urine — 6 liters, 8 liters, or even 10 liters of urine every day.

The lack of these three hormones will lead the organism into a disaster. And they are not replaced. Because what should be done

is not being done, this patient will die within a few days. Nearly these patients will die within a few days due to cardiac arrest. But that’s because you are not considering part of the second Hippocratic oath, which is: you should do the best you can to save the life of your patient. You’re not replacing thyroid hormones; you’re not replacing adrenal hormones; you’re sometimes not replacing ADH, so those patients will die in a few days.

How do those who support “brain death” defend this?

Believe it or not, people who are in favor of “brain death” say it doesn’t matter what you do. They say that, even with the most aggressive intensive care treatment, these patients will die within a few days, so it’s a good idea to take their organs to save the lives of other people. But, actually, those patients have not been treated as they should. The most basic treatment, that is, replacing of all these three hormones, is not done, so the patient will die.

Hypothyroidism is known by the medical community to be a lethal disorder if it’s left untreated. Adrenal failure, which I just described, is also known to be a lethal disorder if it’s left untreated. And the same is true for diabetes insipidus, which is due to the lack of ADH. So, you have three lethal disorders in the same patient, and you don’t treat them. Instead, you say: “Those patients will die even if you give them the most aggressive intensive care treatment.” It’s not true. You don’t know what’s happening. You don’t know the pathophysiology of what is happening with this patient.

Medical doctors are not taught to give thyroid hormones or adrenal hormones; sometimes they are not even taught to give ADH. Doctors sometimes say this is happening “because the brain is dying.” But, actually, the brain is dying because they not replacing those thyroid hormones. If doctors would replace these three types of hormones, the normal circulation to the brain would be restored and the hypothalamus will restart producing normal amounts of all those hormones.

Have you treated patients who have recovered from severe brain trauma through the use of these hormones?

Yes, I treated a 39-year-old woman who was declared “brain dead”... It was a surgical accident that caused the damage to the brain, and I started the replacement of these hormones four days after the event. I have to tell you that it should have started beforehand, not four days later. But she was already diagnosed as “brain dead” and the family had been told. So, we started replacing the thyroid hormones at day four. Eight days after the beginning of the replacement of thyroid hormones and the other hormones, the patient started to breathe on her own. Therefore, the patient could no longer be recognized as someone who is dead, because she was breathing. As I said before, the ability to breathe on one’s own is a sign of life in any culture of the world, so that patient was alive.

One month later, she was able to communicate with her parents. Because she had a tracheostomy she had to communicate by lip reading. She would only move her lips, because there wasn’t sufficient air to vibrate the vocal cords. There was no sound, but she could communicate by lip reading and that continued for two or three months.

Unfortunately, she died because she was in bed too long and she had clot formations within the veins of her legs and the clots moved to her lungs. She died because of pulmonary embolism.

But she was able to communicate with her parents before she died.

Yes, for two or three months she could communicate with them...

Which is all the difference for the family...the fact that the parents were able to communicate with their daughter.

Her brain was functional. Of course, she had some severe neurological problems related to movement. Her movements were severely restricted. But we did not know what would have happened in the next few months, if she would start moving her arms and legs or not. Unfortunately, she had this clinical complication and died because of that.

Since you asked, it is important to say that, before this lady, I treated a 15-year-old girl. I started the treatment one month after the accident. She had already been submitted to three apnea tests. She breathed in the first and the second, but not in the third. They were done on consecutive days, so each of the tests were an additional aggression to the patient, to the brain circulation, and finally she could not resist the third. She was in a deep coma with no respiratory reflexes.

That patient was not in the same city where I worked, and the family moved from another state in Brazil to the state of São Paulo. I started the replacement of the thyroid hormones too late, but at some point, about two weeks later, under thyroid hormone replacement and the replacement of other hormones, that patient was having seizures, convulsions, on the right side.

But a person who is “brain dead” doesn’t have brain seizures, do they?

No, a dead brain cannot have a seizure. That’s what I wrote on the patient’s chart.

The doctor on call that night in the ICU was someone involved in a transplant system. And he wrote something [in the chart] like: “once a patient is declared ‘brain dead,’ the patient is dead. It doesn’t matter if later on the patient no longer fulfills the criteria for ‘brain death.’ The patient is legally dead, because it was once diagnosed as ‘brain dead.’”

I can prove this. I have a copy of the patient’s chart. So, you see the conflict of interest here. In the United States alone, in 2016 the transplant system involved business to the tune of approximately 25 billion dollars. By 2025, it is expected to reach 51 billion dollars per year.

On the internet, you can find announcements suggesting that you should buy shares from those pharmaceutical companies, because they will be increasing profits and you can earn a lot of money by buying their shares. So, this is big, big business. You can see how powerful these people are.

Imagine that you knew a very well-known, prestigious transplant surgeon, who has been performing vital organ transplants for 30 years. He is very skillful surgeon, possibly world-renowned. And then you come to him and say that “brain death” is not death anymore, because now we know much more than we knew in 1968, when brain that was introduced into medicine.

Imagine that you tell him he should stop doing vital organ transplants. He has been doing them for 30 years, and he is very skillful, perhaps a world-renowned doctor. Do suppose that he will accept that peacefully? It’s difficult. After 30 years, all the prestige that has accumulated and then you tell him he should look for another way of making money — another specialty because transplants are no longer possible.

It seems it goes back to the Hippocratic oath. A doctor makes a vow when he becomes doctor. It is a sacred vow.

Yes, definitely.

***<https://www.lifesitenews.com/news/neurologist-exposes-brain-death-myth-behind-multi-billion-dollar-organ-transplant-industry>

See below the complete 41-minute talk by Dr. Coimbra given May 20, 2019 at the John Paul II Academy for Human Life and the Family Conference in Rome.
<https://www.youtube.com/watch?v=2ISpsvW4H68>
