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# Human Heart Transplantation Theological Observations

John J. Lynch, S.J.

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Certainly the most dramatic surgical event of 1967 was the performance in early December of the first transplantation of a human heart from a cadaver into the living body of a second person. The medical outcome of that history-making operation, and of the four others like it which followed in relatively quick succession, is common enough knowledge to forbid repetition here. Moreover, any appraisal of the surgical future of such procedures is rightfully reserved to medical experts. But since much of the world at large is also currently concerned about the moral implications of the matter – man's dominion versus God's dominion with respect to human life; human providence versus divine Providence with respect to death – the following comments from a theological viewpoint may not be amiss.

It should be understood, however, that this discussion is not designed to pass judgment on the morality of any of the heart transplants which have already been performed. That would be a presumptuous undertaking for any theologian at present, since neither authentic medical records nor other relevant data are available to serve as basis for sound moral conclusions. For present purposes it will suffice to consider transplantation of the human heart in the abs t – as though no instance of it ha ever yet occurred – and to t to determine whether and whe the procedure could be approv as morally unobjectionable.

It is to be understood also t the comments to follow are inten d to apply only to medical situati s in which transplantation of a man heart (1) is a necessary measure last resort, (2) offers reasonable h e of substantial benefit to the rec ent, and (3) is performed by an op ting team medically and sur ally competent to carry out this ki of procedure. Although no consci ious surgeon needs to be reminde that these three provisos are all the sine-qua-non variety, it is none eless advisable that, when discussi the question of heart transplant the theologian express himself expli ly in this regard lest he be misunderst d as endorsing irresponsible s gical experimentation.

Just a word in further expla ation of these presuppositions.

1) *A necessary measure o last resort.* This precaution implies th t the patient's condition is so critica that sound medical opinion would judge him to be here and now in grave and relatively proximate danger of death. It further implies that no less drastic

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treatment is likely to be effective in the prolongation of the patient's life. Perhaps as the technique of transplanting hearts is gradually perfected, surgical prognosis will so improve as to allow for some mitigation of this restriction. But as yet the operation is still in the experimental stage and beyond question entails hazards of a very serious kind. Hence the procedure should as yet be considered one of last resort.

2) *Reasonable hope of substantial benefit to the recipient.* Reasonable hope is by no means to be interpreted as a guarantee, but merely as a well-founded medical expectation. Substantial benefit is to be understood principally in terms of prolongation of human life over a period of time sufficiently protracted to compensate for the risks presently entailed in human heart transplantation. Only competent medical authority can judge whether and when this condition is fulfilled. But unless it can be honestly judged to be fulfilled, recourse to heart transplantation would represent a form of human experimentation which could not find moral justification

3) *Medical and surgical competence of the operating team.* This stipulation is self-explanatory and requires no defense of its inclusion in this context. It implies that each participating member of the operating team has been, both in theory and in practice (at least by virtue of sufficient animal experimentation) adequately rehearsed for his part in the total procedure.

On the understanding, therefore, that human heart transplantation would be undertaken only in medical circumstances such as those just specified, what remains to be said about the morality of the procedure?

First, it may be helpful to point out that, theologically speaking, transplantation of any organ from a human corpse presents a far less complicated problem than does an organ transplant from a living donor. For more than a generation, theologians have disagreed as to the licitness of the latter procedure. Some maintain that bodily mutilation – the excision of a living person's kidney, for example – can be morally justified only if it is necessary for the total well being of that same person, as would be the case if malignancy should be discovered in the kidney and nephrectomy therefore deemed necessary in order to save the victim's life. But to sacrifice a healthy kidney for the benefit of another is considered by this school of thought to be in excess of man's right to dispose of his bodily members.

Other theologians, however – and they are most probably in the majority – find justification for this species of transplantation in the law of fraternal love which permits one to do for another whatever one may legitimately do for himself. This more benign opinion is theologically most respectable and may be safely followed in practice under certain conditions which need not be discussed in present context.

This problem of donor mutilation, however, does not arise when organs are removed from cadavera for purposes of transplantation. Clearly a corpse is no longer a person possessed of human rights or subject to human obligations; and although we are not entirely free to dispose of human remains at will, we are considerably less restricted in our rightful

disposition of inanimate bodies than would be the case with the bodily members of the living. It remains to be seen, therefore, what these lesser restrictions may be.

The first proviso relates to the prospective recipient of the heart transplant, and stipulates that his informed consent to the procedure be previously obtained. The reason for insisting upon the observance of this condition is the fact that transplantation of a human heart unquestionably represents at present an instance of extraordinary means of prolonging life. As a very general rule extraordinary medical measures are not of obligation for the patient, who is still within his God-given rights if he chooses to decline treatment so uncertain and hazardous and to allow nature to take its lethal course. Since it is the patient's prerogative to decide whether extraordinary means are to be employed or disregarded, this right should be most carefully respected. Consequently it would be the doctor's responsibility to explain to his patient as objectively as possible the medical pros and cons of the procedure and thereafter to abide by the patient's subsequent decision.

Secondly, consent should also be obtained either from the donor before death or, after his demise, from someone – usually next of kin – authorized to make such a decision. Although doubtlessly there would be instances in which consent could be reasonably presumed, explicit permission, if it can be requested, is by far the preferable alternative.

Finally, the heart is not to be removed from the donor's body until there is moral certitude that medical death has occurred.

Real medical death may be defined as cessation of vital function beyond reasonable hope of resuscitation. But it is for doctors, not theologians to determine the discernible signs by which real death can be verified in concrete circumstances. Without presuming to trespass on medical preserves, one might venture the surmise that theologians generally would perhaps be willing to accept as a working criterion of medical death the provisions of South African law to which Dr. Christiaan Barnard alluded during his year-end interview on CBS Television, viz., simultaneous lack of reflexes, respiration, and heart-beat. If a more precise standard of practical judgment is reasonably available it should, of course, be used.

Under no circumstances, even if the prospective donor is certainly doomed to die within a very short time, may the doctor anticipate death and begin removing the heart from a living human subject. This statement derives from a theological view of man's dominion over human life which up until very recently had been unanimously accepted and taught by Catholic theologians as part of the Church's moral doctrine. It is a theological view which depends upon an essential distinction between the moral obligation not to kill and the moral obligation to keep alive. Only the former is absolute. In accordance with it, direct killing of an innocent human being, even if otherwise already doomed to die, still remains murder. And just as killing out of mercy to the patient would always be wrong, so too killing to obtain a transplant (mercy to another) would always be wrong. Whatever, then, may be the acceptable indications of medical death, these must be verified before one could

allow the removal of an organ so essential to life that its excision would amount to a direct killing.

Technical control over the beginning and ending of human life is ever increasing and is bound to raise a great variety of questions with regard to man's dominion over his members, his functions, and his very being. The solution of these questions will depend to a great extent on one's theological convictions as to the *sacred* inviolability of human life. Is human life especially sacred, not merely because of the essential dignity of a human "personality," but because human life is itself removed from man's dominion and reserved to God's own providence? If so, to what extent is control of human life exclusively of divine right?

Not enough time has elapsed to allow for thorough theological discussion of the heart transplant. But it does not seem likely that any serious moral objection will be lodged against the procedure as long as the above cautions are observed.

## Marquette Medical School Severs Ties with University

All legal ties between Marquette University and its medical school were severed at a special meeting on September 30. The newly reorganized school has been named the Marquette School of Medicine, Inc. The reorganization is intended to remove any obstacles to participation of the school in a medical center for southeastern Wisconsin, in which the school and Milwaukee County General Hospital would be the nucleus.

Both Very Rev. John P. Raynor, S.J., University president, and Father Raymond R. McAuley, S.J., executive vice president, have resigned from the medical school's board of directors. In the past, the president of the University was also president and chairman of the medical school corporation. Under the newly amended incorporation articles, no University officers automatically will be on the board.

Louis Quarles, a senior partner in the legal firm of Quarles, Herriot, Clemons, Teschner and Noelke, has been elected president of the reorganized board to succeed Father Raynor. John W. Cowee, who had been on the board because of his position as vice president of business and finance, has been elected to the board as a public member. He also was elected vice president of the reorganized board. He had been its secretary. Cowee remains vice president of what now is Marquette School of Medicine, Inc.