HEART TRANSPLANTS:
ETHICAL CONSIDERATIONS

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IT HAS NOW BEEN seventy-five years since Housman penned the words:

His folly has not fellow
Beneath the blue of day
That gives to man or woman
His heart and soul away.

(A Shropshire Lad, XIV)

What seemed like a fool's dream just three quarters of a century ago is no longer a dream, and today hardly seems foolish. Revolutionary advances in medical and surgical science have given to man new possibilities.

Yet every new possibility, whether of man's own making or of man's discovery, creates for man a new responsibility. The extent of his potentiality is the extent of his responsibility. Man must respond to that which is and that which can be. That which man controls, he must necessarily direct towards some end. Yet not every goal towards which man can direct his activity is necessarily a moral one. It is not trite to say that not everything which man can do, he ought to do.

Thus man must necessarily raise the moral question. He must ask whether he ought to do what he can do. Not to raise the question is to avoid the issue of responsibility. Even more basically it is for man to abdicate his very being, his free potentiality to pursue rationally determined goals.

Thus it is that since Dr. van Rood of the University of Leiden not quite two years ago developed a primitive method of tissue typing, the possibility of transplanting the most vital of human organs has lain within man's grasp. Even before Dr. Christian Barnard made

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the decision to transplant the heart of Denise Darvall into the body of Louis Washansky, surgeons around the world were looking to the day when such an operation would take place. Yet if the pioneering efforts of Dr. van Rood and those surgeons who have profited from his research have created a new possibility for man, they have also created an ethical problem — or, more precisely, they have actualized a potentiality which raises several ethical questions.

As a matter of fact, it was not long after Dr. Barnard's initial cardiac transplants that a number of moral and ethical issues were raised, that a variety of legislative acts were proposed, and that several moral values were underscored in an attempt to bring some ethical light upon the new surgical procedure. Within the past year, moreover, more than a score of studies has been devoted to the morality of heart transplants. The abundance of this literature, most of it avowedly not very profound, yet responsive to a human need, bears witness to the fact that the possibility of heart transplants among humans necessarily and of itself raises the moral question.

Yet it is true that the possibility of human heart transplants, like every possibility which lies before man, necessarily raises an ethical question, it is also true that the ethical question raised by the heart transplant possibility is, in many respects, a unique question. The morality of heart transplants is a moral issue quite unlike those issues of medical ethics which most doctors and not a few laymen have to face during their lifetimes.

The uniqueness of ethical concern with respect to heart transplants is principally the result of two factors.

In the first place, we are concerned with a vital organ, a vital organ of which only one exists in the living person, a vital organ for which there currently exists no prosthetic substitute. Despite the fact that already four years ago thirteen institutions, with the assistance of grants from the National Heart Institute, had done research work on a number of different types of artificial hearts, no substitute has yet been found for the human heart. Thus both the irreplaceability and the unicity of the human heart make the transplanting of the human heart a unique surgical procedure, vastly different, in its ethical implications, from the transplanting of other vital organs. In a unique fashion, the question of life and death must be faced by those who consider the possibility of a heart transplant. To focus attention upon the ethics of heart transplants is indeed to focus attention upon the life and death of both donor and recipient. Unlike most medical questions of ethical concern, the issue of heart transplants allows for no compromise, and the answer to the question raised permits no correction. This factor alone intensifies the ethical concerns in heart transplantation.

Yet there is another factor to be considered which makes the heart transplant operation something unique for the ethician, if not always and in immediate fashion, for the surgeon. This is the fact that the heart is an organ which has not only biological function, but also symbolic significance. Generations of men have celebrated the heart in song
and art. Men of all cultures have considered the heart as a metonym for the human person. This simply means that there is associated with the human heart a network of significance, not founded on biological data, but which all the same exists. The existence of this symbolic filageree gives an added dimension to the ethical concerns in the matter of heart transplants. Man's emotive and psychic response to the idea of "manipulating" the heart must be considered. We need only think of the prejudice which still exists among large segments of our population with respect to psychiatry to realize that there necessarily exists a number of human problems, spontaneous reactions arising from the subconscious, emotions and attitudes, which must also be our concern when we consider the morality of heart transplants.

It must also be stated that if a new possibility constitutes a new responsibility for man, this same new possibility creates a demand either for the formulation of new norms of behavior or the refinement of the old norms. The statement of ethical principles and of moral norms is not now made in a vacuum, nor were these norms and principles themselves developed in a vacuum. Rather they are the result of inductive reflection upon existing circumstances in the light of a certain value system.

This means that principles and norms are susceptible to change when the situations to which they are applicable change. It means that they are susceptible to change when man's self-understanding changes. It means that it is values which both furnish consistency to evolving moral norms and ever more developed principles, and which serve as the root source of these norms and principles themselves.

The essential value which must occupy our consideration in the matter of heart transplants is the value of human life itself. It is upon human life that other human values are dependent: freedom, truth, health, and dominion. Consequently ethical man has always sought to protect life. Religious man esteems human life not only as the source of human achievement, but more radically as the gift of God to him. He consequently admits that he does not have final authority over the disposition of his own life. His creed is that life itself has value insofar as it is life related to God.

Furthermore, life as it actually exists is life existing in a delicate tension between society and the individual. The life of the individual man is not truly human apart from society; nor can the society of man exist apart from the individual lives of those who comprise society. Thus, the existential value of human life which serves as the necessary criterion of moral judgment is life in tension between the individual and society.

In a word, human life is the value with which we are concerned. As an existential value, however, human life cannot be considered in isolated or abstract fashion. Moreover, human life is a positive value, a value which man, including the man of faith, has sought to protect and promote by surrounding it with a series of positive norms and a number of prohibitions. The moral norms of medical ethics and scientific research have life, human life, in all its
complexity, as their object. It is human life which must be preserved, protected, and furthered.

Indeed, the avoidance of death itself is a moral norm precisely because death is itself the negation of life. In effect, this is to state that the avoidance of death has moral value insofar as it is a means by which life itself is protected. This may seem as a truism or even as a tautology, but it is not. The common sense of mankind and the Christian tradition have never made the avoidance of death an absolute obligation. Indeed, the Christian tradition specifically assigns a positive value to death; and man in his wisdom lauds the death of the patriot and hero. Death, in other words, is endowed with positive significance when it is accepted as a necessary instrument of life, but not when it is sought as the destruction of life.

Christian tradition theologically interprets and celebrates death as it does precisely because it looks to death as a passage to a fuller life. The common estimation of mankind mourns the loss of the patriot-martyr or soldier, but praises his death, because it looks to his death as a means by which the life of the nation is preserved and protected. Society has accepted capital punishment to the degree that it has judged such a punishment necessary to the fuller human life of the greater society; but man's moral sensibilities are affronted when capital punishment is inflicted in a spirit of vengeance and vindictiveness.

This consideration of human life as a basic value, and of death as a disvalue insofar as it constitutes the negation of life, is of paramount importance in the consideration of heart transplants. The reason is simply the fact that man questions first the death of the donor. Press reports have cast some suspicion upon the circumstances of death of some heart donors. It has been widely affirmed that the first heart transplant took place in South Africa because the legal criteria for affirming death were simply the cessation of respiration and heart beat.

As a matter of fact, the issue of the death of the donor is itself a complex one. Was the donor dead when the removal operation was begun? Was the death of the donor hastened or permitted in order to make him a more suitable donor? What are the criteria by which death can be diagnosed? To what extent should the recognition of these criteria be mandated by law? The value is that of human life. The responsibility is that of the doctor and society to protect and strengthen human life. The issue is, however, the definition of death and the discernableness of death.

To look to the death of the donor as the key ethical issue in the matter of cardiac transplants is to call attention to the rights of the donor in surgical procedures of this type.

1. First among his rights is his right to life. All reasonable efforts must be made to restore the donor-patient to a state of health and well-being. To protect the prospective donor's right to life, it has been suggested that two medical-surgical teams be involved in every transplant operation. The first would be charged with the care of the donor-patient, the second with the care of the recipient-patient. Only when the first team has reached the decision that it is impossible
to arrest the impetus towards death of the patient, would the second team be permitted to take charge of the donor-patient. That is, only after prudent medical judgment had affirmed that the patient was in the category of the deceased could he be treated as a donor.

It must, of course be noted that there are several ways of defining death. In one philosophical system, death can be defined as the final separation of soul from body. Clinical death can be described as the cessation of vital functions. Biological death is characterized by cellular decomposition of the brain. In the wake of the early wave of heart transplants, an Ad Hoc Committee of the Harvard Medical School proposed four criteria of death, namely: 1) unreceptivity and unresponsivity; 2) the absence of spontaneous muscular movement; 3) the loss of reflexes; and 4) a flat electro-encephalogram (EEG) reading.

Yet as precisely as the criteria indicating death may be refined, it must always be remembered that the indication of death is not to be equated with death itself. In man's human existence, his personal reality transcends its bodily expression. The physical body of man is a sign and expression of man's personal being. Death affects man in his personal being. Physical signs of death are an indication of death. They are not death itself. Death itself is the irreversible and, of itself, imperceptible cessation of vital activity.

This having been noted, it must be repeated that the prime area of medical responsibility is the preservation and development of human life itself, not the mere avoidance of death.

2. The prospective donor has, none-theless, a right to die. Death is part of the human condition. To be human is to be in movement towards death. Consequently the prospective donor should enjoy the exercise of one of his rights, esteemed most highly by the Christian tradition, namely his right to die in peace and dignity.

This necessarily raises the question of the prolongation of life in a physical, rather than personal sense with a view towards the utilization of organs in transplant operations. Although the goal is laudable, the procedure is of questionable ethical quality, especially if the procedure is employed contrary to the previously expressed will of the donor himself.

3. The donor has a right to freedom and personal autonomy. His right to his personal autonomy implies that he has the first and proper right to determine the final disposition of his body and his bodily organs. If he has the right to dispose of his properties and other possessions, he also has the right to dispose of his body and its organs, the very first and most expressive of his possessions. This right includes the right to designate a specific beneficiary in any given instance.

The donor's right to personal autonomy, to self-disposition, is a right which no other individual and no society can legitimately usurp. The donor must be free from coercion in the decisions which he makes with respect to the disposition of his organs. His freedom from coercion must be protected, if necessary by legislation, in the days ahead. Dr. Theodore Cooper, the director of the National
Heart Institute, has estimated that there may be as many as 81,000 potential beneficiaries of human hearts in the United States each year. To meet the potential need, the hearts of approximately one third of all who die from causes other than cardiac failure and cancer will be needed. Undoubtedly there will arise the danger of coercion being brought to bear upon potential donors.

The donor’s right to personal autonomy further implies that the potential donor be supplied with the information necessary for him to make his decision wisely. He should be apprized of the possibility of designating his organs for the use of others, as well as of the good which can accrue to another and to society because of a successful transplant operation. Responsibility for conveying such information rests upon society as a whole, and specifically upon the physician attending the patient-potential donor.

To assure that the right of the individual to dispose of his body and its organs is respected, some Uniform Anatomical Gifts legislation would seem to be required. Such legislation would recognize the prior claim of the potential donor’s expressed will with regard to his bodily organs and would facilitate the rapid execution of a heart transplant operation — this, of course, to the greater benefit of the beneficiary.

With respect to the donor, it must also be noted that the principle which serves as the most accurate criterion for a moral judgment in the area of organ transplantation is not the principle of totality — and certainly not the principle of totality, narrowly conceived. Rather the operative principle must always be concern for one’s fellow man, that concern which Christian tradition calls charity and which it recognizes as the summit of moral perfection.

4. The donor has, furthermore, the right to privacy. The donor should not be allowed to become the object of public wonder. Both he and his family should not be made subject to public scrutiny. Even a public figure is entitled to privacy. A fortiori a private individual, in tragic circumstances, enjoys the same fundamental human right. And yet respect for the privacy of the donor and his family is often violated by those whose quest for curiosity leads to impolite reporting and ill-advised publication. Such action is basically a denial of a fundamental human right.

5. Finally, the donor has the right to bodily respect. He has a right to expect considerate treatment of his body after death. He has a right to a burial in keeping with his religious beliefs and traditions. Christian tradition has consistently considered the body as the temple of the Holy Spirit and has consequently demanded that even the bodies of the deceased be treated with reverence and respect.

If the donor of a heart has his rights, so too does the family of the donor. They have secondary and subordinate rights over the body and vital organs of the donor. In the exercise of these rights they are morally bound to follow the wishes of the donor, even if these wishes have not been expressed in a form which is legally binding (e.g., a will).

The family of the donor likewise has a right to privacy, particularly during a
period of bereavement. Finally, the family has a right to make a judicious decision. This implies that they have a moral right to sufficient knowledge about the proposed transplant operation so that they can make a decision in rational and human fashion. It also implies that the decision be made with sufficient deliberation and serenity of spirit. All parties to the discussion on the possibility and feasibility of organ transplantation must carefully consider the personal turmoil with which the family of the deceased are often afflicted at the time of death. Tragic circumstances do not always allow for or lead to the most prudent decision.

From the donor and his family our attention should then turn to the doctor and his surgical team. Doctors are primary witnesses to natural law obligations in the matter of heart transplants. Ethically and morally they are bound to protect and promote human life. By a quasi-contractual agreement they are bound to care for the life and health of their patients. Their experience gives them the ability to judge most prudently in matters of life and death. Consequently their expressed or implicit judgment should be regarded by all as a primary witness to ethical concern.

Doctors, moreover, have their rights which society has a duty to protect. Doctors must be protected against lawsuits emanating from unscrupulous patients and their relatives. Yet the protection which they should be afforded under law should not be given at the price of over-legislation which would impede medical progress.

Finally, with regard to doctors, a distinction must be made between experimental procedures and therapeutic procedures. At the present time the heart transplant operations are not similarly judged by the surgeons who have performed them. Thus Dr. Shumway has spoken of a "clinical trial," whereas Dr. Barnard speaks of "therapy."

To make such a distinction is not to reject experimentation as intrinsically immoral. Experimentation is necessary for the advance of medical knowledge and surgical science, but such experimentation is justifiable only when it has the welfare of man in view and only if it takes place after sufficient preparations have been made and similar experimentation has been performed on sub-human forms of life.

Nor does this distinction intend to deny that surgical procedures which are primarily intended to be beneficial to the patient, in this case to the recipient of the transplanted heart, are often still in an experimental stage of development. Certainly the use of such experimental means is warranted when the use of more commonly accepted procedures is judged to be ineffectual. Rather, the distinction must be stressed in order to underscore the fact that the rights and obligations of the parties to a heart transplant operation assume a different form according to the nature of the surgical procedure.

Furthermore, it must be acknowledged that society also is a party to heart transplant operations. It is more than an interested observer. In a very real sense society is involved in heart transplant operations — and society also has its rights.

Society as a whole has a right to the
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protection of life as a societal value. It cannot afford that human life be reduced to the level of an object of clinical manipulation. It has the right, and consequent duty, to protect and promote the human life and personal subjectivity of each of its citizens.

It is in keeping with this essential right that society itself must confront the question, “Who shall live, and who shall die?” It is difficult to establish specific criteria for answering the question, but some general indications can certainly be offered.

1. The relative chances for success in a transplant operation and the prospects for a return to normal activity must be carefully weighed. From the moral standpoint, he who has a greater possibility of return to a normal life has a greater claim to a new heart than he for whom the new heart will, given, for example, the deterioration of other vital organs, merely prolong life without restoration to a state of relatively normal vitality.

2. The general good of society must also be considered. Normally this value is best protected when all potential donors are considered ex aequo. However, the value to society of a given individual — and I would think that the number of such individuals is relatively small — could result in a prior claim to a new heart of that individual over the rights of other members of society.

Indeed, society protects all of its members, but affords a special protection to the President because of his value to society. For society to recognize the priority of claim of a given individual to a new heart is simply an extension of its recognition that certain members of society are so valuable that they must be protected by more than ordinary measures.

3. The time factor can serve as a final criterion by which an answer to this burning question can be formulated. All other factors being equal, “first come, first served” can function as a rule of thumb to preserve equity in determining the rights of prospective heart recipients.

Finally, in order to safeguard the right to life of prospective recipients, society has the obligation to look to the establishment of banks in which the vital organs, including the heart, can be preserved with a view to later use.

This remark leads to a consideration of the rights of the recipient in a heart transplant operation. His rights can no more be neglected than can those of the donor.

1. The prospective recipient has the right to his own humanity and a right to life. As a human person, he is radically the equal of other human beings. As a child of God, he is the equal of other children of God. As a citizen, he is the equal of other citizens. Consequently each prospective recipient has radically the same right to life that others do. Accidental considerations of wealth and status are, and must remain, independent of man’s essential and inalienable right to life. Man’s fundamentally equal right to life must be protected, if necessary, by legislation in the area of public health and insurance regulation. It is radically immoral for finances to be the determining factor in the exercise of man’s right to life, since each man’s life is essentially as sacred as that of his neighbor.
2. The recipient has a right to his personal identity. It may be that the transplant of a human heart leads to serious psychological sequelae in the recipient. Recently, for example, the *British Medical Journal* (1968, p. 539) has reported a case in which the transplant of a kidney from a female donor to a male recipient constituted a threat to the recipient’s sexual identity. Given the extensive network of associations surrounding the human heart, there is reason to believe that some identity crisis can be caused by a heart transplant.

3. The recipient has the right to expect reasonable success in the transplant operation. When such success cannot reasonably be assured, he has the right to such information as will enable him to make a reasonable decision.

4. The recipient of a new heart, has, furthermore, the right to privacy. An individual who has been involved in a heart transplant operation does not, by that very fact, become public property. As a human being he has a fundamental right to lead his private life, sheltered from the public gaze. Privacy is, after all, necessary to the development of a life that is fully human. Man’s privacy must be protected as a sign of respect for the sacrosanctity and inviolability of the human person.

Finally, and by way of conclusion, it must be stated that there are several human rights and a plurality of authentic values to be protected in heart transplant operations. Of these the most sacred is life itself, which the Christian esteems as the gift of God to man. To protect the gift of life itself, the greatest possible measure of freedom and discretion should be accorded to doctors. Insofar as it is possible, the judgment of those who have devoted their lives to the preservation and development of human life should be respected.

After life itself, the most sacred of human rights is the right to personal autonomy. It is a right whose exercise is limited by the rights of others. It is a right which is not absolute, yet a right which ought not to be usurped. Society is, after all, not the lord of its members; that role belongs only to the Creator.