Reflection on the Surgical Code

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One hundred years ago last August as the country was on the heels of a global pandemic, the Surgical Code was finalized by Fr. Michael Bourke and enacted at Detroit-area hospitals. Just one-page long, with only 14 instructions, this "Code would come to serve as the precursor to the *Ethical and Religious Directives for Catholic Health Care Services (ERDs)*, currently in its sixth edition.

HISTORY OF THE CODE AND FR. MICHAEL BOURKE

"History repeats itself." Believers affirm this claim; critics reject it. A mediation may bridge these sides, particularly in the Surgical Code's case, namely that historical situations and events mimic others with slightly dissimilar contexts. The Surgical Code was written and given a *nihil obstat* and *imprimatur* in the wake of a horrific pandemic. What has been called "the Spanish flu" was first identified in military service members in the spring of 1918. It went on to infect one-third of the world's population (500 million) and kill 675,000 in the U.S. and 50 million worldwide according to the CDC on the "1918 Pandemic." The nation was reeling from the pandemic, prolonged conflict, and different ideas about the presence of the U.S. on the world stage. Catholic health care was present as well, serving the common good and the needs of the underserved while looking for new ways to do so. The value of health care ethics was recognized by Catholic health care, as evidenced by an Ethical Committee at the Catholic Hospital Association (CHA) in the early 1920s.

Despite historical similarities there are stark differences, especially for Catholic health care. Religious congregations of women and men were widely involved in health care operations and administration. The provision of Catholic health care looked worlds apart from how it appears today. For instance, vowed religious practiced and taught others to care for minds, bodies, and spirits. Lay leaders were uncommon, and groups we're accustomed to today, such as pastoral care or palliative care departments, were nonexistent or far-cries from contemporary counterparts.

"Necessity is the mother of invention." Appreciating the Surgical Code entails equal regard for its key architect, Fr. Michael Bourke, whose bedrock was practicality as much as faith, duties to God and the faithful, and regard for the law. Fr. Bourke had a CV impressive in any and every century. He was a lawyer who served as Assistant Attorney General of Michigan, was ordained in 1914, was in the administration of St. Joseph Mercy Hospital in Ann Arbor where he was also the first hospital chaplain, and chaired CHA's Ethical Committee, the group that crafted the Surgical Code. While at St. Joseph Mercy Hospital, he took up

communities' needs, coordinated proper care for those with cognitive and behavioral health issues, and organized and reorganized hospital departments for better service.[1]

"Be practical as well as generous in your ideals. Keep your eyes on the stars, but remember to keep your feet on the ground."[2] On the one hand, the Surgical Code's 14 directives seem negative, like a list of don'ts. They focus mostly around Part 4 of the ERDs today and specific procedures ("before operating, the surgeon will tell the sister in charge of the OR what procedure he will perform"). As a result, they appear heavy handed in the black-and-white compared to the 6th edition. On the other hand, this was a poster intended for surgeons that hung on OR-area walls, meant for quick reference between or during surgery. Anecdotally, we have heard it had to be anchored at the bottom due to the breeze in open-air ORs. Fr. Bourke worked on the "Code" as he worked with women and men on restructuring obstetrics and gynecology at St. Joseph Mercy Hospital to meet the needs of women and their babies. The Surgical Code is the penultimate in pragmatism for a Catholic OR — an amalgamation of moral teaching, condensed to a list of short tenets.

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While it applied to just a few hospitals rather than the entire country, the Surgical Code was a precursor to the ERDs. So, we thought this an opportune time to reflect on the ERDs and their wonderful contributions to Catholic health care today.

REFLECTION ON THE ERDS OF TODAY

"I didn't have the time to make it shorter."[3] We do not appreciate often enough how much there is much to admire in the ERDs as a teaching document. They condense thousands of years of theology, hundreds of magisterial documents, and millions of pages written by theologians over the centuries into 30 pages and 77 Directives. Pause a moment to think about the precision and concision necessary for such a feat. Without these Directives, clinicians, ethicists, theologians, and leaders in Catholic health care would be forced to comb through a mass of documents to find applicable teaching or relevant theological thought. Imagine trying to quickly summarize Church teaching on complying with OSHA or EEOC regulations without Directive 7, or scour *Dignitatis humanae* and other documents to explain why a Catholic hospital should hire non-Catholic chaplains without Directives 11 and 22. Both of us have worked with Catholic hospitals and Catholic bioethicists in other countries that do not have a similar document.[4] We can personally attest to the added difficulty of working without the ERDs.

While "the Directives do not cover in detail all of the complex issues that confront Catholic health care today", they are rather comprehensive. They provide a metaphysical foundation in "the physical, psychological, social, and spiritual dimensions of the human person." With this basis, they delve into how

Catholic health care should attend to these social and spiritual needs (Parts 1 and 2), provide the professional-patient relationship (Part 3) as context for unique issues at the beginning (Part 4) and end (Part 5) of life, and describe the need to contribute to the common good and maintain moral integrity (Part 6).

"Definition is the formula of the essence."[5] Some of the content and definitions are found elsewhere in magisterial teaching (such as euthanasia or common good), and several definitions are found only in the ERDs (such as proportionate/disproportionate means and abortion). How much more difficult would complex moral dilemmas at the beginning of life be without the guidance of Directives 45 and 47? Our ability to work through end of life cases would be much poorer without the definitions in Directives 56 and 57. To be certain, the content is consistent with the broader moral tradition, but these specific definitions in these four Directives are not found anywhere else. The practicality they offer is indispensable for anyone working through dilemmas with actual patients.

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While everyone finds connection with different passages or Directives, two in particular stand out to us. First, Directive 3 applies the Preferential Option for the Poor in such practical terms that our mission in Catholic health care is indisputable. It calls us to serve, advocate for, and treat all people, but especially those who are marginalized. Yet, in the true fashion of practical, actionable guidance, it provides long enumeration of marginalized groups; only five Directives are longer in content. We have found this list to be an efficient expression of the breadth of our call to care for the poor and vulnerable.

Second, the description of the professional-patient relationship is radically different from that found elsewhere in health care today. The Introduction to Part 3 describes it as a relationship of "mutual respect, trust, honesty, and appropriate confidentiality." Caregivers and patients both have rights and responsibilities. In health care, we frequently discuss patient rights and professional responsibilities, but too often we overlook the responsibilities of patients and the rights of professionals. Part 3 emphasizes this reciprocal give and take as it lists and describes specific rights and responsibilities for all involved. Neither the "professional nor the patient acts independently of the other; both participate in the healing process." This mutual pursuit of a shared goal is a beacon of light in a health care system that increasingly focuses on consumer needs and trends toward the commodification of health care as a service.

"Our God-given dignity and the rights that arise from it are the ultimate foundation of all social life."[6] In honor of the 100th anniversary of the Surgical Code on August 1, 2021, we invite our colleagues to read the ERDs again with an eye towards appreciation for the succinctness, practicality, and direction they provide. Of the 77 Directives, 58 contain positive moral obligations, only 11 are negative obligations,

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and 8 contain a combination of both. Contrary to some often-heard criticism, they are more than "the list of things we can't do." The vast majority are things we must and should do. First and foremost, "a commitment to promote and defend human dignity." The ERDs call us to attend to the fullness of the human person to allow each person we encounter to flourish, be they patient, physician, or employee. The ERDs paint a compelling moral vision of Catholic health care done well. Health care that makes the healing presence of God known in our world and extends the healing ministry of Jesus Christ. ✠

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ENDNOTES

1. Catherine Whitaker, *A Tradition of Mercy: A History of St. Joseph Mercy and Mercywood Hospitals Ann Arbor, Michigan* 1911-1979, Catholic McAuley Health Center History, vol. 1 (Ann Arbor, MI: Catherine McAuley Health Center, 1983).
2. Theodore Roosevelt, Address at Groton School, May 24, 1904, p. 6.
3. Blaise Pascal
4. To our knowledge, only the bishops in Australia, Canada, and Ireland have created something similar for their countries.
5. Aristotle, Metaphysics, 1042a19
6. Pope Francis, General Audience, August 12, 2020.

Reflection Questions

1. How do you see the ERDs as helpful in your role?
2. How would you change the ERDs to meet the needs of today and the future?
3. What do you take away from this article as it relates to the history of the ERDs?