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New Mexico's *Uniform Health-Care Decisions Act*

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Introduction

New Mexico's *Uniform Health-Care Decisions Act* (UHCDA) is modelled on a draft uniform statute of the same name produced in 1993 by the National Conference of Commissioners on Uniform State Laws.[1] Two years later, New Mexico became the first state to enact the law, closely following the original draft.[2,3] An understanding of the provisions of the statute is necessary to appreciate the implications it may have for freedom of conscience for health care practitioners.

The UHCDA was originally drafted as a response to the "confused situation" that developed in relation to end-of-life treatment following the 1990 U.S. Supreme Court decision in *Cruzan v. Commissioner, Missouri Department of Health*.[1,4] However, in its final form, the draft comprehensively addressed medical decision-making in all circumstances, not just at the end-of-life or in relation to patients lacking capacity.

Scope of New Mexico's UHCDA

New Mexico took this approach in its own UHCDA in 1995.2 The *Act* applies to "health care practitioners" and "health care institutions," terms defined broadly enough to include physicians, nurses, pharmacists, psychologists, hospitals, hospices, clinics, etc. It defines health care as "any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition." A "health care decision" is 'a decision made by an individual or the individual's agent, guardian or surrogate, regarding the individual's health care." Such decisions *include* — this non-restrictive term is important —

> (1) selection and discharge of health-care practitioners and institutions;
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> (2) approval or disapproval of diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate;
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> (3) directions relating to life-sustaining treatment, including withholding or withdrawing life-sustaining treatment and the termination of life support; and
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> (4) directions to provide, withhold or withdraw artificial

nutrition and hydration and all other forms of health care (emphasis added).

It is thus clear that the UHCDA applies to abortion and would apply to practitioner assisted suicide and euthanasia, should those procedures be legalized. Since the *Act* is intended to ensure compliance with informed medical decisions made by patients or their authorized surrogates, the provisions concerning health care practitioners and institutions unwilling to provide services are especially significant.

UHCDA provisions on refusing to comply with decisions

The *Act* states that health care practitioners and institutions may refuse to act upon instructions or decisions that would require them to provide "medically ineffective health care or health care contrary to generally accepted health-care standards." It further defines "medically ineffective health care" as "treatment that would not offer the patient any significant benefit, as determined by a health-care practitioner" (emphasis added). However, while practitioners and institutions are legally entitled to exercise independent medical judgement in determining whether or not a treatment is effective and beneficial, doing so can be contentious.

In addition, the *Act* states that health care practitioners may refuse to comply with patient instructions or decisions "for reasons of conscience." Similarly, it permits institutions to refuse services or procedures that contradict institutional policies "expressly based on reasons of conscience," provided that patients or their substitute decision-makers are given "timely" notice of the policies.

Obligations of refusing practitioners and institutions

Whether the refusal is for reasons of medical judgement or reasons of conscience, the *Act* imposes three obligations upon practitioners and institutions. The first two are unexceptionable. They must promptly notify patients or their agents of the refusal, and they must continue to provide care pending transfer to another practitioner or institution.

The third obligation is potentially problematic. Refusing practitioners and institutions must "immediately make all reasonable efforts to assist in the transfer of the patient to another health-care practitioner or health-care institution that is willing to comply with the individual instruction or decision," unless the patient refuses assistance.

Making "all reasonable efforts to assist" in transferring patients

No problem arises if this is understood to mean that practitioners and institutions must immediately cooperate in transfers of care initiated by patients or their substitute decision makers. When a patient finds a practitioner or institution willing to provide the contested service and a transfer is requested, objecting practitioners and institutions are typically willing to cooperate by transferring records, cooperate with transportation arrangements, etc. Practitioners and institutions cooperate respectfully with a patient's exercise of autonomy, but do not to help to arrange for or otherwise actively facilitate procedures they refuse to provide for reasons of medical judgement or conscience. In the Project's experience, this arrangement is generally acceptable to objecting practitioners and institutions.

However, a problem would arise if "making all reasonable efforts to assist" is interpreted to require objecting practitioners and institutions to actively and purposefully help the patient find and connect with someone willing to provide a contested service. Many would be unwilling to do this because they reasonably believe that doing so would make them complicit in what they consider to be medically inadvisable or immoral actions.

Which is the correct meaning of the provision, or, at least, the most plausible?

Understanding the obligation to assist

The most plausible interpretation is the first. It appears that 1993 draft UHCDA was understood to to require practitioners and institutions to cooperate in a patient-initiated transfer of care, not to require them to actively help to arrange for the patient to obtain the service from another provider. There is no reason to think that the New Mexico legislature took a different view two years later. This conclusion is warranted for two reasons.

First, official observers of the drafting committee included the Catholic Health Association of the United States (CHAUSA).[1] The Catholic Church in the United States was and continues to be strongly opposed to laws that would compel physicians or institutions to actively support or facilitate services or procedures contrary to Catholic teaching, such as abortion and euthanasia. Had the draft been understood to impose such an obligation, CHAUSA and the United States Conference of Catholic Bishops (USCCB) would most certainly have protested, but they did not. Second, while the USCCB has been critical of some elements in the UHCDA from the beginning, this is not one of them.[5]

Nonetheless, the most plausible interpretation is unlikely to satisfy activists intent on suppressing freedom of conscience in health care. They are more likely to assert that the UHCDA requires objecting practitioners and institutions to actively facilitate morally contested procedures by referral and other means - including abortion, euthanasia and assisted suicide.

Notes

1. National Conference of Commissioners on Uniform State Laws. Uniform Health-Care Decisions Act [Internet]. Chicago, Illinois: Uniform Law Commission; 1993 Jul 30-Aug 6 [cited 2021 Feb 13]. Available from: https://www.uniformlaws.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=ecc54f21-ed44-3b22-7350-4b4861e751c9&forceDialog=1.

2. *P. & a.v. Presbyterian Healthcare Services*, 989 P (2d) 890, 128 NM 73, 1999-NMCA-122, (1999). Justia [Internet]. Mountainview, California; 2021 [cited 2021 Feb 13]. Available from: https://law.justia.com/cases/new-mexico/court-of-appeals/1999/20-385-2.html.

3. The Portal of Geriatrics On-line Education: Geriatric Medicine- Health Care Decision Making [Internet]. Nashville, TN: Icahn School of Medicine at Mount Sinai and Vanderbilt University School of Medicine. [cited 2021 Feb 13]. Available from:

https://pogoe.org/sites/default/files/health_care_decision_making_module.pdf.

4. *Cruzan v. Commissioner, Missouri Department of Health*, 497 US 261 (US 1990). Justia [Internet]. Mountainview, California; 2021 [cited 2021 Feb 13]. Available from: https://supreme.justia.com/cases/federal/us/497/261/.

5. Anthony R. Picarello, Jr., Michael F. Moses. (Office of the General Counsel, United States Conference of Catholic Bishops, Washington, DC). Letter to: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Washington, DC) [Internet]. Washington, DC: United States Conference of Catholic Bishops; 2015 Sep 4 [cited 2021 Feb 13]. Available from: https://www.usccb.org/about/general-counsel/rulemaking/upload/Comments-Advance-Directives-Medicare-9-15.pdf.