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New Mexico assisted suicide bill subverts freedom of conscience for health care practitioners

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Introduction

House Bill 47 (the *Elizabeth Whitfield End-of-Life Options Act*) was introduced in the New Mexico house in January, 2021. It would amend existing criminal law to permit "medical aid in dying" (assisted suicide). That is, physicians and advanced practice nurses to prescribe lethal medication to eligible patients, who may then ingest the medication to cause death.[1] HB 47 defines this as a medical practice [§2E], which has significant implications for all health care practitioners in the state. The bill also includes definitions and provisions that conflict with New Mexico's *Uniform Health-Care Decisions Act* (UHCDA).[2]

The concern here is the impact HB 47 is likely to have on health practitioners who object to assisting in suicide for reasons of conscience. For this purpose it is necessary to review some of the *Act*'s key provisions, but a number of procedural and reporting requirements and collateral provisions need not be considered.

Overview of HB 47

Qualified patients

Patients will qualify for assisted suicide if they are at least 18 years of age, capable of making and communicating informed health care decisions, have an incurable or irreversible terminal disease or condition likely to cause death within six months, and are able to self-administer lethal medication [§2A,B, §3A]. At least one physician must certify capacity, terminal illness and the ability to self-administer, so advanced practices nurses would have to arrange for this [§3F].

Basic conditions for prescribing lethal medication

Lethal medication can be prescribed for a qualified patient after a health care provider has

> (a) provided information necessary to enable informed decision-making [§3C],
>
> (b) determined that the patient is not being coerced or unduly influenced [§3A(3),D], and

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(c) provided medical care "in accordance with accepted medical standards of care."[§3B].

The *Act* is silent with respect to a patient's legal right to refuse even efficacious treatment, but this right is recognized by accepted medical standards. Thus, the law would permit health care providers to provide lethal medication to patients who refuse ameliorative treatment capable of extending life beyond a six month prognosis.

Assisted suicide to be offered to all terminally ill patients

If the *Act* passes in its present form, *all* physicians and advanced practice nurses ("health care providers") will be required to advise *every* patient diagnosed with a terminal illness that assisted suicide is a treatment option, including mentally ill or intellectually disabled patients [§4], whether or not the patient expresses an interest in it [§6]. One may infer that the timing of the notice is at the discretion of the practitioner, and that the option need not be presented to minors or to those plainly lacking capacity, but this still includes a very large number of patients and does not specify if there is an obligation to offer assisted suicide if capacity or other issues are in doubt.

Collaboration in assisted suicide required

Health care providers unable or unwilling to provide assisted suicide must so advise patients and facilitate assisted suicide by referring them to a health care provider "able and willing" to do so, transferring medical records upon request to the new provider [§9D].

Falsification of death certificates

The *Act* requires the falsification of death certificates by describing the cause of death as the underlying illness or condition rather than suicide by ingestion of lethal medication [§7, §10]. This raises a number of issues.[3] A law requiring falsification of death certificates by practitioners implies that planned and deliberate deception is a professional obligation, and this would be problematic for those who take codes of ethics seriously. It also implies that practitioners may have an obligation to mislead or lie to families and others about the cause of death.

Ingestion of lethal medication

Anyone — health care provider or not, minor or adult — may assist in the suicide of someone prescribed lethal medication in accordance with terms of the bill. The authorization is completely unrestricted [§12]. Nonetheless, the bill does not authorize "lethal injection, mercy killing or euthanasia" by anyone [§10]. Thus, a prolonged or unsuccessful assisted suicide cannot be expedited or "completed" by lethal injection, as is the practice in the Netherlands[4] and soon will be in Canada.[5]

Hospitals, hospices, clinics, etc.

The *Act* acknowledges that health care entities (clinics, hospitals, hospices, etc.) may prohibit assisted suicide on their premises, but requires them to state the prohibition "accurately and clearly" on websites or materials given to patients [§9K]. They cannot prevent employees from "providing" assisted suicide elsewhere, *or* from "providing" assisted suicide when not acting within the scope of their employment [§9E]. "Providing" must mean prescribing lethal medication [§2E].

Health care entities can sanction employees who "participate in" assisted suicide on their premises or when acting within the scope of their employment, if they have notified them in advance that they may not do so [§9F]. "Participate in' would seem to be broader than "providing," and may extend to activities closely related to prescribing lethal medication.

However, the *Act* states that nothing in the section can be construed to prevent health care providers from"participating in" assisted suicide outside an employer's premises *or* outside the scope of their employment. It also allows providers to contract privately with patients to participate in assisted suicide outside the scope of their employment [§9G]. This seems to imply that providers who have privately contracted with patients to provide assisted suicide can evaluate patients and write prescriptions for lethal medication on an objecting employer's premises, notwithstanding having been notified that they cannot do so, as long as they are not acting within the scope of their employment.

"Conscience-based decisions" (§9)

The provisions of the Act that address "conscience-based decisions" are convoluted, and they are prejudiced against those unwilling to be involved in assisted suicide. For example, a report of unprofessional conduct can be made *only* against health care providers who *refuse* to participate [§9J]. It is easiest to establish what kinds of conduct are *not* protected by the *Act*.

Conduct *not* protected

Refusing to offer assisted suicide: The *Act* imposes an absolute requirement to present assisted suicide as a treatment option to every terminally ill patient, even if the patient has not expressed interest in it. There is no exemption for providers unwilling to do so for reasons of conscience or medical judgement. Those who fail or refuse to do so are liable to civil actions, regulatory sanctions and discipline and sanctions by professional associations and employers.

This is a significant problem because providers may be reluctant or unwilling to suggest assisted suicide to patients who are mentally ill or have other conditions contributing to their vulnerability. Even those who do not object to assisted suicide in principle may be concerned that patients may be unduly influenced to choose assisted suicide if it is suggested by a health care practitioner. Concern about undue influence underlies prosecution guidelines for encouraging or assisting suicide in the United Kingdom, which state that prosecution is more likely in the case of health care practitioners and others who have the care of a patient.[6] Similarly, legislation in the state of Victoria, Australia, states that practitioners must not initiate discussions about "assisted dying" (i.e., euthanasia/assisted suicide) with patients.[7]

Refusing to collaborate in assisted suicide: Many providers who object to assisted suicide find referral to an assisted suicide provider unacceptable because they reasonably believe that connecting their patients with someone willing to give them lethal medication entails complicity in the suicide of their patients. Even prominent activists who demand that objecting physicians should be compelled to refer patients for morally contested procedures admit that referral entails complicity and is not a compromise.[8,9,10,11] The Act actively suppresses freedom of conscience in this regard and exposes those unwilling to collaborate in assisted suicide to criminal and civil liability, regulatory sanctions, and discipline and sanctions by professional associations and employers [§9].

Refusing to falsify death certificates: The *Act* does not protect anyone who refuses to falsify death certificates, whether for reasons of conscience, because they are concerned that falsifying death certificates will undermine trust in the profession, or because they believe the practice will distort vital statistics data. State authorities, professional associations and employers may take action against those who refuse to comply [§7, §10].

Refusing to be present: The *Act* does not require a health care provider to be present when lethal medication is ingested by a patient, but it protects anyone who chooses to be present. On the other hand, it provides no protection for anyone who *refuses* to be present [§9A(2)]. This is significant, since (as in Canada) regulators may require physicians, nurses or others to be present when lethal medication is ingested,[12] even if the *Act* does not; employers might impose the same requirement.

Identifying protected conduct

The *Act* identifies but does not define four different kinds of conduct to which immunities or exemptions apply to varying degrees:

- *providing* medical assistance in dying [§9E];
- *participating in* medical assistance in dying [§9A(1), F, G, J];
- *participating in the provision of* medical aid in dying [§9B, D];
- *being present* when lethal medication is ingested [§9A(2)] .

"Medical aid in dying" means *only* the act of prescribing lethal medication to a qualified patient for the purpose of self-administration (§2E). Based on this, it seems reasonable to infer that:

- "*providing* medical assistance in dying" means only writing the prescription;
- "*participating in* medical assistance in dying" means doing something closely connected to prescribing and self-administration, such as dispensing lethal medication, explaining how it is to be used and helping the patient to ingest it.
- "*participation in the provision of* medical aid in dying" refers to actions more distantly connected to but essential for or causally connected to writing the prescription and self-administration, such as evaluating patient capacity, writing reports, acting as a witness and delivering the lethal medication.
- "*being present*" does not amount to participation.

Protection against state and professional sanctions

Anyone (professional or non-professional, health care provider or not) who agrees or refuses to *participate in* "medical aid in dying" is protected from civil and criminal liability, licensing sanctions and other professional disciplinary action [§9A(1)]. It appears this protection is not available for those who refuse to *participate in the provision of* medical aid in dying (i.e., evaluate patients, write reports, deliver lethal medications, etc.), nor to those who refuse to be present when lethal medication is ingested.

Protection against sanctions by health care agencies and providers

Anyone (professional or non-professional, health care provider or not) who agrees or refuses "to *participate in the provision of* medical aid in dying" is protected against sanctions by health care entities, professional organizations or associations, health insurers, managed care organizations and health care providers [§9B]." This is the broadest protection offered by the *Act*. It appears to extend to activities like evaluating patients, writing reports, delivering lethal medications, etc.

Unprotected entities

Hospitals, hospices, pharmacies, clinics etc. are licensed to provide health care, but under the *Act* they "health care entities," not health care providers [§2C]. As noted above, the *Act* acknowledges that they can prohibit assisted suicide on their premises and authorizes them to prevent employees acting in the course of their employment from participating in the procedure. However, it does not protect them from civil liability if they choose to do so.

Position of the New Mexico Medical Society

In January, 2019, the New Mexico Medical Society Council unanimously adopted the following resolution:

> RESOLVED, that NMMS adopt a position of engaged neutrality regarding medical aid in dying in order to serve as a resource to lawmakers, physicians and the public, to ensure that medical aid in dying be practiced only by a duly licensed physician in conformance with standards of good medical practice and statutory authority, and to protect physicians' freedom to participate or not participate in medical aid in dying according to his or her personal conscience.[13]

The first point to note is that the resolution does not define "medical aid in dying" and thus pertains to both euthanasia and assisted suicide, though legislative efforts in the state have thus far been confined to assisted suicide. The second is that the resolution is not specific to a particular bill, but to the issue of euthanasia and assisted suicide generally. Thus, the resolution cannot be understood to imply support for the provisions of HB 47 by the Society.

Further, the emphasis placed on physician freedom of conscience in the resolution was reinforced in another resolution adopted at the same meeting. In supporting the repeal of New Mexico's abortion law, the Council stressed that it is important to "[p]reserve opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice" in order to preserve "the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely."

"Thus," the Council insisted, "physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities."[13]

As has been demonstrated here, HB 47 is prejudiced against those unwilling to be involved in causing the death of their patients. It not only fails to provide adequate protection for practitioner freedom of conscience, but attacks it directly by demanding collaboration in assisted suicide. Thus, the resolution leaves open the possibility that the Society will oppose the bill unless it is substantially

amended.

The treacherous notion of "engaged neutrality"

It appears that the Society has adopted the view that euthanasia and assisted suicide can conform to "standards of good medical practice," the implication being that the procedures can be medical procedures. Notwithstanding the intentions of Council, the position that euthanasia and assisted suicide can be medical procedures is not a neutral position *vis-à-vis* the nature of the practice of medicine or the ethics of the medical profession. Those opposed to euthanasia and assisted suicide often insist that both are inconsistent with the practice and medicine and cannot ever be provided in accordance with "standards of good medical practice."[14]

Further, it is important to recognize that objecting practitioners are placed at a significant disadvantage when euthanasia and assisted suicide are accepted even conditionally as medical practices. This has been clearly demonstrated in Canada.[15] The Canadian Medical Association adopted a policy of "neutrality" about the procedures in 2014, but went on to affirm that they are legitimate forms of end-of-life care and are "medical services," with disastrous consequences for objecting Canadian physicians:

> By redefining euthanasia and assisted suicide as therapeutic medical services, the CMA made physician participation normative for the medical profession; refus-ing to provide them in the circumstances set out by law became an exception requiring justification or excuse. That is why public discourse in Canada has since centred largely on whether or under what circumstances physicians and institutions should be allowed to refuse to provide or collaborate in homicide and suicide . . . [16] (references omitted)

Notes

1. US, HB 47, An Act Relating to Health Care; Enacting the Elizabeth Whitefield End-of-Life Options Act; Amending a Section of Chapter 30, Article 2 NMSA 1978 to Establish Rights, Procedures and Protections Relating to Medical Aid in Dying; Establishing REporting Requirements; Removing Criminal Liablity for Providing Assistance Pursuant to the Elizabeth Whitefield End-of-Life Options Act., 55th Legislature, First Session, NM, 2021 [Internet]. Santa Fe, NM: New Mexico Legislature; 2021 [cited 2021 Feb 15]. Available from: https://www.nmlegis.gov/Sessions/21%20Regular/bills/house/HB0047.pdf.

2. Chapter 24, Article 7A NMSA, Uniform Health-Care Decisions [Internet]. Mountainview, California: Justia 2021 [cited 2021 Feb 16]. Available from: https://law.justia.com/codes/new-mexico/2019/chapter-24/article-7a/.

3. Murphy S. A bureaucracy of medical deception: Quebec physicians told to falsify euthanasia death certificates. Regulators support coverup of euthanasia from families [Internet]. Powell River BC: Protection of Conscience Project; 2015 Nov 17 [cited 2021 Feb 16]. Available from: https://www.consciencelaws.org/background/procedures/assist012.aspx.

4. Dutch guidelines acknowledge that assisted suicide is not a "preferred method" of causing the death of the patient because it may take several hours and complications can arise. If death does not occur within an agreed-upon time (a maximum of two hours), physicians are to provide a lethal infusion. See Royal Dutch Medical Association, Royal Dutch Pharmacists Association. KNMG/KNMP Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide [Internet]. Utrecht: Royal Dutch Medical Association; 2012 Aug [cited 2021 Feb 16]. Available from: https://www.knmg.nl/web/file?uuid=bc11990b-d37a-4fa9-9e36-69d34bd229db&owner=5c945405-d6ca-4deb-aa16-7af2088aa173&contentid=223&elementid=2003770.

5. The original amendment to the *Criminal Code* authorizing euthanasia and assisted suicide stated that practitioners must, immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent [Criminal Code, RSC 1985,c C-46,s. 241.2(3)(h)]. However, because of the requirement for last-minute consent by a patient, it was not clear if a prolonged or unsuccessful assisted suicide could be legally completed by euthanasia in the case of a patient who had become incompetent during the procedure. This is being remedied by a government bill now before Parliament that will permit assisted suicide to be expedited or completed by euthanasia if a patient has provided written consent in advance. {Canada Bill C-7, An Act to amend the Criminal Code (medical assistance in dying) 2nd Sess, 43rd Parl, 2020, cl 3.5 (as passed by the House of Commons 10 December, 2020) [Internet]. Ottawa: Parliament of Canada; 2020 Dec 10 [cited 2021 Feb 16]. Available from: https://parl.ca/DocumentViewer/en/43-2/bill/C-7/third-reading}.

6. Director of Public Prosecutions. Suicide: Policy for Prosecutors in Respect of Encouraging or Assisting Suicide [Internet]. London: Crown Prosecution Service; 2010 Feb, updated 2014 Oct [cited 2021 Feb 16]. Available from: https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide.

7. Voluntary Assisted Dying Act 2017 (Vic) s 8 [Internet]. Melbourne: State Government of Victoria; 2020 Jun 19 [cited 2021 Feb 16]. Available from: https://content.legislation.vic.gov.au/sites/default/files/2020-06/17-61aa004%20authorised.pdf

8. McLeod C. Demanding Referral in the Wake of Conscientious Objection to Abortion. In JC Cohen JC JE Keelan JE, eds. Comparative Program on Health Law and Society, Lupina Foundation Working Papers Series 2004–2005 [Internet]. Toronto: University of Toronto, Munk Centre for International Studies, 2006; [cited 2021 Feb 17]. Available from: munkschool.utoronto.ca/cphs/wp-content/uploads/2012/11/CPHS2004_WorkingPapers1.pdf.

9. Kantymir L, McLeod C. Justification for Conscience Exemptions in Health Care. Bioethics. 2014 Jan;28(1):16-23. doi: 10.1111/bioe.12055. Epub 2013 Sep 30 [cited 2021 Feb 17]. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/bioe.12055.

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11. Savulescu J, Schuklenk U. Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception. Bioethics. 2017 [cited 2021 Feb 17];31(3):162-170. doi:10.1111/bioe.12288. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/bioe.12288

12. The original provisions of the Criminal Code authorized euthanasia and assisted suicide but imposed no requirement for practitioners to be present when lethal medication is ingested in a case of assisted suicide. An amendment currently before Parliament will require a practitioner to be present in order to expedite or complete assisted suicide by euthanasia (See note 5). However, state medical regulators can require practitioners to be present in all cases (e.g., College of Physicians and Surgeons of British Columbia. Practice Standard: Medical Assistance in Dying [Internet]. Vancouver, BC: CPSBC; 2020 Jul 24 [cited 2021 Feb 17]. Available from: https://www.cpsbc.ca/files/pdf/PSG-Medical-Assistance-in-Dying.pdf.

13. New Mexico Medical Society Council Meeting Minutes: Saturday, January 5, 2019 [Internet]. Amazon Cloudfront: 2021 [cited 2021 Feb 17]. Available from: https://d2zhgehghqjuwb.cloudfront.net/accounts/14766/original/2019_1_5_Council_Minutes_-_PENDING_APPROVAL.pdf?1547577653.

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15. Murphy S. Canadian Medical Association and euthanasia and assisted suicide in Canada: Critical review of CMA approach to changes in policy and law [Internet]. Protection of Conscience Project; 2018 Sep 26 [cited 2021 Feb 17]. Available from: https://www.consciencelaws.org/background/procedures/assist029-01.aspx.

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