June 29, 2023

Sent via email to:
Mr. Jim Heckert, CEO, Gerald Champion Regional Medical Center
jheckert@gcrmc.org

Re: Your community has questions - Transparency needed for the Gerald Champion Regional Medical Center and CHRISTUS Health transaction.

Dear Mr. Heckert:

Otero County community leaders have brought to our attention that Gerald Champion Regional Medical Center ("GCRMC") has engaged in long negotiations behind closed doors with CHRISTUS Health ("CHRISTUS") and has recently announced plans to join their system as early as July 1st. Numerous community members have contacted the ACLU of New Mexico expressing concerns about this action, its lack of transparency, and about the future of health care provision in the region. We share their concerns.

It's clear from your public statements that you appreciate the importance and complexity of this transaction, we urge leadership at GCRMC to ensure that, if GCRMC joins the CHRISTUS Health system, the approval is accompanied by robust and *enforceable* conditions that ensure Otero County residents and others served by or working for GCRMC can access the health care services they need - including comprehensive reproductive health care, LGBTQ+ inclusive health care patients, including gender affirming care for transgender patients, and end-of-life care options.

While it remains unclear if and how associated clinical sites will be joining the CHRISTUS Health system, as the sole community Level III Trauma hospital dedicated to serving South Central New Mexico, a safety net care provider for the region, and a facility with a Department of Defense Shared Facility Agreement, we ask that you take this opportunity to build trust with those you serve by, at the very least, extending that time frame, particularly given the repeated assurances that GCRMC is not in financial distress, in order to have documented, careful, and considered dialogue with your community.

The ACLU of New Mexico, Bold Futures NM, and concerned community leaders and residents of Otero County invite GCRMC and CHRISTUS Health including the *Ethical and Religious Directives for Catholic Health Care Services* ("ERDs"), prior to a completed transaction, to join a facilitated conversation where those you serve and employ and/or contract with can get much needed answers, and provide feedback to one of the most important health care providers in the region and largest non-governmental employer in the county. Those who receive healthcare at this facility deserve an uninterrupted continuum of care that meets the true needs of the community. GCRMC and its tremendous health care providers and staff deserve to continue providing and expanding first-rate care to individuals in Southern and Southeastern New Mexico in line with their medical expertise, not the ethical directives of a religious entity. The community served by GCRMC needs answers to their questions and written assurances that essential health care will continue to be available to patients who need it.

In addition, we provide the attached information as GCRMC decides how it will proceed.

Sincerely,

Ellie Rushforth
Managing Attorney - Reproductive Rights and Gender Equity
American Civil Liberties Union
erushforth@aclu-nm.org

/s/ Charlene Bencomo

Charlene Bencomo
Executive Director
Bold Futures NM
charlene@boldfuturesnm.org

CC:

- Mr. Ernie Sadau, CEO, CHRISTUS Health
- Ms. Lillie Lewis, RN, Gerald Champion Regional Medical Center

- Concerned Otero County Leader
- Concerned Otero County Leader
- Concerned Otero County Leader
- Concerned Otero County Leader
- Concerned Otero County Resident
- Concerned Otero County Resident
- Concerned Otero County Resident
- Concerned Otero County Health Care Provider
- Concerned Otero County Health Care Provider
- Concerned Otero County Health Care Provider
- Concerned Otero County Health Care Provider
- Concerned Otero County Health Care Provider

- Concerned Otero Community Organization

- The Office of Governor Michelle Lujan Grisham
- The Honorable Bernalyn “Gina” Via, Acting President, Mescalero Apache Tribe
- CEO Dorlynn Simmons, Mescalero Indian Health Service
- Attorney General Raúl Torres
- Solicitor General Alethia Allen
- The Office of Senator Ben Ray Luján
- The Office of Senator Martin Heinrich
- The Office of Representative Gabe Vasquez
- 49th Wing Public Affairs Office: Attn: Col. Justin B. Spears, Commander, 48th Wing, Holloman Airforce Base, New Mexico & Chief Master Sergeant Jeffery D. Martin.
- Cabinet Secretary Patrick Allen, Department of Health
- Deputy Secretary Dr. Laura Parajon, Department of Health
- Acting Cabinet Secretary Kari Armijo, Health and Human Services Department
- Superintendent Alice T. Kane, Office of Superintendent of Insurance
- Alamogordo Mayor Susan L. Payne
- Otero County Commission
- Alamogordo City Commission
- Otero County Healthcare Services Department
- Otero County Health Council
- Indigenous Women Rising
- Southwest Women’s Law Center
- ProgressNow NM
- New Mexico Religious Coalition for Reproductive Choice
- End of Life Options New Mexico
- Community Catalyst

The impact of the *Ethical and Religious Directives for Catholic Health Care Services* ("ERDs") on hospital administration, employees, and patient care.[1]

As you know, GCRMC is the largest hospital in the region and the only level III trauma center serving Otero County residents, Holloman Air Force Base service members and their families, the Mescalero Apache Reservation, surrounding areas, and incarcerated individuals in the prison and jails in the region. GCRMC also manages numerous on and off-site clinics including the White Sands Women's Health Clinic, Champion Urgent Care, Family Practice, Pediatrics of Alamogordo and a cancer center. While every practice area could be impacted by this acquisition, it is critical the community you serve has a clear understanding of how their health care will be altered by the *Ethical and Religious Directives for Catholic Health Care Services* ("ERDs").

In brief, the ERDs reduce access to care in New Mexican communities, and place religious doctrine over the independent, scientifically and evidence based, medical judgment of health providers – to the detriment of both patients and providers.

<u>Hospital Administration, Employees, and Clinician Employees or Contractors</u>

Hospital Administration

Mr. Heckartt, GCRMC CEO, has responded to concerned community members by saying that the ERDs are not "black and white" and decisions will be made by clinicians. Residents of Otero County must be able to trust that health care will go unchanged, but the (Ethical and Religious) Directives of the Catholic church are explicit:

- "While the following Directives are offered to assist Catholic health care institutions in analyzing the moral considerations of collaborative arrangements, the **ultimate responsibility** for interpreting and applying of the Directives rests with the **diocesan bishop**."
- "Catholic health institutions **may not** promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning."
- The decision to "withdraw life sustaining procedures shall always be **respected…unless** it is contrary to Catholic moral teachings."
- "In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to

[1] *Ethical and Religious Directives for Catholic Health Care Services*, U.S. Conf. Cath. Bishops (6th ed. 2018), available at http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf.

make an advance directive for their medical treatment. The institution, however, **will not honor** an advance directive that is contrary to Catholic teaching."

- "Employees of a Catholic health care institution **must…adhere** to these directives."
- "Direct sterilization of either men or women, whether permanent or temporary, is **not permitted** in a Catholic health care institution."
- "The Church **cannot approve contraceptive interventions** that 'either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, have the purpose, whether as an end or a means, to render procreation impossible.' Such interventions violate 'the inseparable connection, willed by God . . . between the two meanings of the conjugal act: the unitive and procreative meaning.'"
- "Reproductive technologies that substitute for the marriage act are **not consistent with human dignity**"
- "Representatives of Catholic health care institutions who serve as members of governing boards of non-Catholic health care organizations that do not adhere to the ethical principles regarding health care articulated by the Church should make their opposition to immoral procedures known and not give their consent to any decisions proximately connected with such procedures. Great care must be exercised to **avoid giving scandal** or adversely affecting the witness of the Church."

The application and interpretation of the ERDs ultimately rest with the Catholic Church and diocesan bishop - not a patients' licensed medical provider. The purported gray area between the explicit ERDs becomes even more concerning because providers are required to risk investigation, punishment, job loss, and moral injury just for providing evidence-based health care to their patients - patients who may not ultimately be able to get anybody to actually take the risk of performing a procedure or prescribing medication in such a murky and risky setting.

Under the ERDs, a male Bishop (the Catholic Church prohibits women from being ordained as bishops) interprets this doctrine and will ultimately decide who gets what care. Health care will no longer be governed by the standard of care, but whether or not the Catholic Church and local Diocese has deemed health care, or individuals themselves, **"morally wrong," "intrinsically evil," "illicit," "scandalous," or "inconsistent with human dignity."** The confusing and unpredictable variation in how hospitals apply the ERDs have led to delayed and denied health care, compromised clinician autonomy, and have caused patients and their families severe harm.[2]

[2] Julia Kaye, Brigitte Amiri, Louise Melling, and Jennifer Dalven, *Health Care Denied: Patients and Physicians Speak out about Catholic Hospitals and the Threat to Women's Health and Lives*, Health Care Denied, Nov. 2, 2016, available at https://www.aclu.org/report/report-health-care-denied; *see also* T.S. Mendola, The Fight to Treat Patients at Catholic Hospitals, Rewire News Group, Dec. 5, 2022.

The most recently updated ERDs include directives related to "collaboration" and includes "any kind of collaboration, whatever comes under the control of the Catholic institution—whether by acquisition, governance, or management…" All such mergers "must be operated in full accord with the moral teaching of the Catholic Church, including these Directives." They explicitly require that before mergers are approved, Catholic institutions must ensure that none of their administrators or employees will "manage, carry out, assist in carrying out, make its facilities available for, *make referrals for*, or benefit from the revenue generated by immoral procedures."[3] We have heard mention of "pathways" and "workarounds" that ensures care will be provided to patients even if the care is not available at the hospital - we encourage GCRMC to provide information on if, when, and how this "pathway" will be created and implemented and how CHRISTUS will honor those agreements.

While receiving or providing basic health care should require a "work around," these assurances remain vague and unenforceable. Proponents of hospital consolidations often uplift "referrals" or "work arounds" as a potential solution to denials of care, but referrals are also insufficient. Patients, including LGBTQ+ individuals, women, and the terminally ill, should never feel judged or unwelcome at a health care facility because of their identities or personal health care decisions. These referrals also delay care, undermine continuity of care, and can dramatically increase stress that negatively impacts poor health status. Nor is a referral in some instances safe or even feasible. For some end-of-life patients transferring from one set of providers to another is simply not an option. Additional complications and risks also increase for patients in rural areas, where access can be limited to a single health facility. In these instances, health care entity restrictions may result in insurmountable barriers to care. Moreover, for all patients, the risk of COVID-19 exposure is increased when patients are turned away and forced to go to multiple health facilities in order to seek access to care.

It is critical to get assurances *in writing, prior to* joining a Catholic hospital system that patient care will not fall below the standard of care - including standards related to informed consent and referrals, that patients will still be able to access health care without increased costs and burdens to the patient, and that employee benefits and medical judgment will be respected.

Employees, and Clinician Employees or Contractors

It is also common practice for Catholic health care institutions to require employees to sign contracts that explicitly prohibit the employee from providing care in separate clinical settings that the religiously affiliated system of care finds contrary to the ERDs. Thus, even employees'

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[3] Hayley Penan & Amy Chen, *The Ethical & Religious Directives: What the 2018 Update Means for Catholic Hospital Mergers*, National Health Law Program, Jan. 2, 2019. https://healthlaw.org/resource/the-ethical-religious-directives-what-the-2018-update-means-for-catholic-hospital-mergers/#_ftn14

“off campus’" time could be regulated by the Catholic Church. And, as discussed below, contraception and sterilization may only be covered under employee health benefits if there is a “secondary diagnosis”, without which these services for an employee or their family member would be considered “morally unacceptable” and not covered by insurance. Some Catholic health benefit plans have also discriminated against LGBTQ+ employees and their families by denying certain coverage otherwise offered to opposite-sex married persons.[4] So, in addition to the extreme burden placed on employees navigating the ERDs while trying to provide necessary health care for patients, they must also do so while navigating their own right to access care and that of their families while facing a significant loss in coverage.

Beyond the individual employee and contractor implications, the ERDs that govern the way health care is delivered in Catholic health facilities and systems are often incorporated into lease agreements and employment agreements, and clinicians must agree to abide by the ERDs to obtain admitting privileges at Catholic hospitals.

<u>Family Medicine Residency Program</u>

In its 2021 Community Needs Assessment, GCRMC identified family medicine and primary care as crucial to the health care needs of Otero County. The Family Medicine Residency Program may be impacted if GCRMC joins CHRISTUS. For example, the program’s initial accreditation from the Accreditation Council for Graduate Medical Education (ACGME) could be compromised as some of the core competencies are prohibited directly and indirectly by the ERDs. For example, “[r]esidents must have at least 100 hours (or one month) or 125 patient encounters dedicated to the care of women with gynecologic issues, including well-woman care, family planning, contraception, and options counseling for unintended pregnancy” and “[r]esidents must have at least 200 hours (or two months) dedicated to participating in pregnancy-related care.” ACGME Program Requirements for Graduate Medical Education in Family Medicine, effective July 1, 2022, IV.C.3.h) & 1). Plainly, provision of essential aspects of reproductive health care, including referrals for care and patient education on contraception and pregnancy options counseling, are prohibited under the ERDs - putting the program in direct conflict with accreditation requirements.

<u>Access to Comprehensive Reproductive Health Care</u>

When patients seek reproductive health care, they should be confident that their clinicians will provide them the best care possible and counsel them on their full range of options. They should not have to worry about a lack of appropriate, patient-centered care because of a hospital’s policy-based exclusions. Yet policy-based exclusions, like the ERDs, can violate basic evidence-based standards of care, therefore going against accepted medical practice as adopted by the major professional medical associations. These restrictions prevent willing clinicians from practicing evidence based medicine in accordance with their training and legal obligations. These

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[4] Brad Dress, *Illinois-based Catholic hospital system plans to deny LGBTQ workers fertility coverage*, The Hill, July 18, 2022.

restrictions directly harm patients by stripping them of their autonomy in medical decision-making, creating unnecessary barriers to care, and risking their health.

Hospitals that follow the ERDs restrict some of the most commonly requested contraceptive methods in the United States.[5] For example, Rebecca Chamorro, a patient at Mercy Medical Center Redding in California, decided with her doctor that she would get a tubal ligation during her scheduled C-section. But the hospital refused her doctor's request to perform the procedure, citing the ERDs classifying sterilization procedures as "intrinsically evil." The hospital had also allowed some women to access postpartum tubal ligation while refusing the same service to others. The ACLU of Southern California filed a lawsuit in 2015, arguing that withholding pregnancy-related care for reasons other than medical considerations is illegal.[6]

Similarly, in direct contradiction of medical guidelines, some hospitals that follow the ERDs have denied patients life-saving treatment for dangerous pregnancies because there are still fetal heart tones, even if the pregnancy is not viable and treatment is necessary to preserve a person's health or save their life. For example, the ACLU of Michigan represented Tamesha Means, who sought care at Mercy Health Partners when her water broke at 18 weeks of pregnancy. The hospital sent her home twice even though she was in excruciating pain, there was almost no chance her pregnancy would survive, and continuing the pregnancy posed significant health risks. The hospital did not tell Ms. Means that ending her pregnancy was an option – or that it was the safest option in her situation. In fact, Ms. Means returned to the hospital a third time with an infection and in extreme distress, and the hospital was poised to send her home again when she began to deliver; only then did the hospital treat her miscarriage.[7]

GCRMC should secure a commitment from CHRISTUS Health that reproductive health services, counseling, and referrals will be maintained and put protocols in place to ensure those services are available equally and transparently to all patients prior to finalization of this action.

Treating LGBTQ+ patients with dignity and respect

Patients seeking LGBTQ+ inclusive care, including gender-affirming care, should not fear denial of services simply because of their identity. However, while the ERDs do not specifically discuss queer, transgender, non-binary, and gender nonconforming patients, these individuals routinely face barriers to accessing basic health care services at facilities bound by the ERDs.

[5] Stulberg, Debra B et al., *Tubal ligation in Catholic hospitals: a qualitative study of ob-gyns' experiences*, Contraception vol. 90,4 (2014): 422-8. doi:10.1016/j.contraception.2014.04.015.

[6] *Chamorro v. Dignity Health*, ACLU of Southern California, available at https://www.aclusocal.org/en/cases/chamorro-v-dignity-health-religious-refusals (last visited July 23, 2021).

[7] *Tamesha Means v. U.S. Conference of Catholic Bishops*, ACLU, available at https://www.aclu.org/cases/tamesha-means-v-united-statesconference-catholic-bishops (last visited July 26, 2021).

Additionally, U.S. bishops have begun a process that will explicitly lead to a ban on provision of any form of gender affirming care in Catholic hospitals.[8] This ban would formalize an already routine practice by ERD-bound hospitals of denying access to this necessary care. For example, a California court ruled in 2019 that Evan Minton was discriminated against when a Dignity Health hospital canceled his hysterectomy two days before the scheduled procedure when the hospital learned he is transgender. Dignity Health regularly permits hysterectomies to be performed when the procedure is not part of a person's gender affirming care. This discriminatory denial of care flies in the face of leading evidence-based standards of care; the U.S. Department of Health and Human Services has joined the vast majority of expert medical associations in attesting to the mental and physical health benefits of gender affirming care, and that its provision is safe, effective, and often life-saving.[9]

Furthermore, health care facilities bound by the ERDs cannot provide certain fertility treatments and assisted reproductive technology services, such as in vitro fertilization, gestational surrogacy, and sperm/ovum donation, to assist individuals in growing their families, particularly affecting LGBTQ+ people.

New Mexico has robust anti-discrimination laws and standards that explicitly protect LGBTQ+ individuals and their families. Patients in New Mexico deserve access to the same quality and standard of health care no matter where in the state they have to access this care. To be denied access to health care or receive provision below standards of care due to one's identity is simply unacceptable.

<u>End-of-Life Care Options and Respect Advanced Directives</u>

The ERDs prohibit the full range of end-of-life options, including the refusal of unwanted or non-beneficial medical treatment, such as medically assisted nutrition and hydration, and removal from life-sustaining treatments, such as ventilators, including if a person is in a "permanent vegetative state." Sometimes, clinicians at institutions bound by the ERDs cannot even provide patients with notice of their options and referrals to facilities that do allow the full continuum of end-of-life care. And most concerning, they may also refuse to transfer patients to a facility where their medical decisions will be honored. Patients and their families often lack the information necessary to make informed end-of-life decisions until it is too late, denying patients their fundamental autonomy in medical decision-making.

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[8]*DOCTRINAL NOTE ON THE MORAL LIMITS TO TECHNOLOGICAL MANIPULATION OF THE HUMAN BODY,* Committee on Doctrine United States Conference of Catholic Bishops, March 20, 2023, available at https://www.usccb.org/resources/Doctrinal%20Note%202023-03-20.pdf

[9]See S.E. Smith, *He needed a gender-affirming procedure. The hospital said no,* Vox, (Nov. 01, 2019), available at https://www.vox.com/thehighlight/2019/10/25/20929539/catholic-hospitals-religious-refusal-rural-health-careevan-minton (last visited July 25, 2021) (describing experiences of patients refused care while trying to access gender-affirming surgery and in vitro fertilization at hospitals following the ERDs); *Minton v. Dignity Health, American Civil Liberties Union*, available at https://www.aclu.org/cases/minton-v-dignity-health (last visited July 25, 2021); See Exec. Law §296[2][a]; Civ. Rts. Law §40-c[2]; 9 NYCRR §466.13(c) (clarifying discrimination on the basis of gender identity is sex discrimination).

Disproportionate Impact on People of Color

Due to structural inequities and racism deeply embedded in the health care system, restrictions on care disproportionately impact patients of color, particularly Black and Native women who are more likely to die from pregnancy or childbirth complications or experience unintended pregnancy than white patients, and who are also more likely to receive care nationwide in a facility bound by the ERDs.[10]

Violations of New Mexico State Laws and Regulations: The ERDs interfere with patients' and providers' ability to exercise their rights under New Mexico law and regulation.

New Mexico has consistently led the nation in championing laws that protect bodily autonomy, health care decisions, LGBTQ+ rights, prohibit discrimination, and ensure access to health care to our most vulnerable community members. Beyond that, numerous laws and regulations protect patients and providers in the receipt and provision of care.

This transaction will affect the health, safety and welfare of GCRMC patients, and it should not be licensed by the Department of Health until adequate assurances are made that services will remain available at the hospital and that the governance of the hospital conforms to state regulations and laws. This is particularly important as GCRMC is a safety net care provider in and the sole level III trauma center in the region, a health care provider for incarcerated and indigent individuals in Otero County, recipient of state funds, and a Medicaid provider.

Department of Health Oversight, Required Care and Services, and Reproductive Health Care

We encourage GCRMC to work with the Department of Health to ensure compliance with relevant laws and regulations. The Department of Health has both the authority and the duty to ensure compliance with all relevant statutes and regulations. Under NMSA 24-1-5B: The

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[10] *Racism in Obstetrics and Gynecology: Statement of Policy, The American College of Obstetricians and Gynecologists*, February 2022, available at https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/racism-in-obstetrics-gynecology; Health Care Disparities: Our Commitment to Changing the Culture of Medicine & Eliminating Racial Disparities in Women's Health Outcomes; The American College of Obstetricians and Gynecologists, available at https://www.acog.org/about/our-commitment-to-changing-the-culture-of-medicine-and-eliminating-racial-disparities-in-womens-health-outcomes; Kira Shepherd, Director, Racial Justice Project; Elizabeth Reiner Platt, Director; Katherine Franke, Faculty Director; Elizabeth Boylan, Associate Director, School, *Bearing Faith: The Limits of Catholic Health Care for Women of Color,* Center for Gender and Sexuality Law Public Rights/Private Conscience Project, Columbia Law School, Jan 2018, available at https://lawrightsreligion.law.columbia.edu/sites/default/files/content/BearingFaith.pdf.
Women of Color More Likely to Give Birth in Hospitals Where Catholic Beliefs Hinder Care, Advancing New Standards in Reproductive Health, University of California San Francisco, available at https://www.ansirh.org/news/women-color-more-likely-give-birth-hospitals-where-catholic-beliefs-hinder-care; Maryam Guiahi, *Catholic Healthcare Hurts Black Women*, Conscience Magazine, November 4, 2021, available athttps://www.catholicsforchoice.org/resource-library/catholic-healthcare-hurts-black-women/.

department is authorized to make inspections and investigations and to prescribe rules it deems necessary or desirable to promote the health, safety and welfare of persons using health facilities.

Pursuant to regulation NMAC 7.7.2.6C, the role of the department is to "[r]egulate such hospitals in providing the appropriate level of care for patients." The failure of GCRMC to fully disclose how its policies and procedures will change upon the completion of this partnership could obscure important factors from the Department's review. NM rules also give the department the broad authority to deny a license or renewal for "noncompliance with applicable laws and regulations."[11] Specifically, the entity formed by this partnership should not be licensed until the parties set forth a specific plan to the department establishing how they will provide "required care and services."[12] "Required care" under the regulations includes routine preventive care for indigent patients[13], emergency care for low-income and non-paying patients[14] and care rendered on a non-discriminatory basis.[15]Reproductive health services are also statutorily required services based on the New Mexico Family Planning Act. The Family Planning Act, Section 24-8-6, states:

> A. No health facility shall include in its bylaws or other governing policy statement a statement that:(1) interferes with the physician-patient relationship in connection with the provision of any family planning service; or (2) establishes or authorizes any standard or requirement in violation of Section 5 of the Family Planning Act, provided that nothing in the Family Planning Act shall be construed to require any hospital or clinic that objects on moral or religious grounds to admit any person for the purpose of being sterilized.
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> C. No license or a renewal of a license shall be issued by the state to a health facility if it is in violation of the provisions of Subsection A of this section.

Under Section C, if a hospital does not comply with this provision, it cannot be licensed. This is not discretionary on the part of the Department. This means that the Department cannot issue a license to the entity formed by the partnership until the parties disclose what, if any, restrictions will be placed on reproductive health care and/or sets forth its plan to provide all reproductive health services. Further, Section 24-8-7 provides for publicly funded family planning services to indigent persons. Since the county commission is responsible for evaluating all services made available to indigents, we believe that the county commission has a duty to ensure that indigents will not suffer a diminution in access to family planning services as a result of this transaction.

Uniform Health Care Decisions Act

In its adoption of the Uniform Health-care Decisions Act and applicable case law that defines health care decisions broadly, the New Mexico Legislature and New Mexico Courts have made clear that it is the public policy of this state to ensure that a patient "has the right to make his or

[11] NMAC 7.1.7.7(G)
[12] NMAC 7.7.2.15(F).
[13] NMAC 7.7.2.8.B(2).
[14] NMAC 7.7.2.8.(D).
[15] NMAC 7.7.2.19A(1)(a).

her own health-care decisions. . . ."[16] This statute comprehensively regulates the adherence to a patient's advance directives in order to guarantee their wishes are never compromised.

More specifically, NMSA § 24-7A-7(D) mandates "that a health-care provider or health-care institution providing care to a patient shall comply: (1) before and after the patient is determined to lack capacity, with an individual instruction of the patient made while the patient had capacity." Subsection (H) clarifies that "A health-care provider or health-care institution may not require or prohibit the execution or revocation of an advance health-care directive as a condition for providing health care." While it is true that NMSA § 24-7A-7(E) provides exceptions for decisions of conscience, neither GCRMC nor CHRISTUS have made it clear if and when an advanced health care directive will be honored, when the ERDs purport to override a patient's wishes and the law, and how the entities inform patients of the ERD restrictions.

Patient's Bill of Rights

New Mexico has codified a patient's bill of rights, which requires the governing board of the hospital to ensure that policies are in place to implement its provisions.[17] GCRMC has not informed the public of how it intends to implement certain provisions of the patient's bill of rights which potentially conflict with restrictions on care under the ERDs. Prohibitions on certain reproductive health services, LGBTQ+ health care services, and end-of-life care may violate NMAC 7.7.2.19A(1)(a) of the patient's rights regulation, which forbids discrimination on the basis of religion or sex. While a hospital is allowed to apply for a waiver or variance of these service requirements under NMAC 7.7.2.17(A), the community has not been informed of any intent to apply for a waiver or variance.

Elizabeth Whitefield End-of-Life Options Act

Providers may choose whether to participate in Medical Aid in Dying, however, Catholic health care systems prohibit their employees from participating in medical aid in dying or providing comprehensive end-of life options counseling — yet under this law no healthcare system can prohibit their employees from providing information about medical aid in dying to patients or referring patients to supportive healthcare systems if the patient asks.

Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd

Catholic hospitals across the country routinely, inappropriately, and unlawfully deny pregnant people emergency medical care. Catholic hospitals are not exempt from complying with these laws and cannot invoke their religious status to jeopardize the health and lives of pregnant people seeking medical care. To the contrary, the state and federal laws mentioned above protect patients' right to receive emergency reproductive health care.

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[16] NMSA § 24-7A-2. *See also Protection and Advocacy Systems, Inc. V. Presbyterian, 1999-NMCA-122, 128 N.M. 73, 76-77.*
[17] NMAC 7.7.2.19A.

Beyond the circumstances described in *Health Care Denied*[18], additional examples were also documented in an article in the American Journal of Public Health.[19] The refusal to provide timely reproductive health care to pregnant people seriously threatens their health and lives.

Our goal is to support community members as they advocate for themselves and ensure that all Otero County community members have access to a full range of lawful, quality health services, and that no patient is refused access to such care on the basis of CHRISTUS Health policies.

Although community members will have additional questions, concerns, and feedback, all of which merit timely written responses, we specifically recommend that GCRMC obtain the following in writing:

1. Secure a commitment that all reproductive health services, family planning and contraception, options counseling, and referrals will be maintained and protocols put in place to ensure those services are **available equally and transparently** to all patients and employees. Procedures must be medically defined and align with evidence-based standards of care. Additionally, that emergency health care services including emergency contraception for assault survivors will be available without additional and inaccurate ovulation testing in violation of NMSA § 24-10D-3.
2. Secure a commitment that the Family Medicine Residency Program will be able to meet its core competency and accreditation requirements.
3. Secure a commitment that all LGBTQ+ patients and employees will be treated with dignity and respect, and that the hospital will allow providers to deliver the standard of care – gender affirming and otherwise – to transgender, non-binary, and gender non-

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[18] *Supra* n.2.
[19] *See* Lori R. Freedman, et al., *Where There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 Am. J. of Public Health 1774 (Oct. 2008). Examples included in this article include:

• A doctor in the Northeast decided to leave a Catholic-owned hospital after he was forced by the ethics committee to risk a pregnant patient's life. The woman was in the process of miscarrying at 19 weeks of pregnancy. She was dying: her temperature was 106 degrees, she had disseminated intravascular coagulopathy, which is a life-threatening condition that prevents a person's blood from clotting normally and causes excessive bleeding. This patient was bleeding so badly that the sclera, the whites of her eyes, were red, filled with blood. Id. at 1777. Despite the fact that there was no chance the fetus could survive, the ethics committee told the doctor that he could not perform the abortion the woman needed to save her life until the fetus's heartbeat stopped. The patient was in the Intensive Care Unit for ten days, and developed pulmonary disease, resulting in lifetime oxygen dependency.

• One doctor in a Western urban area described how a Catholic-owned hospital asked her hospital to accept the transfer of a pregnant patient who was in the midst of miscarrying and needed emergency care because she was septic and hemorrhaging. The patient needed the pregnancy to be terminated to prevent further risk to her health, which the Catholic hospital refused to allow the doctor to do, even though transporting her while she was unstable created additional risks to her health. Id. at 1776.

• In another situation, a doctor working at a Catholic-owned hospital in the Midwest was forced to send her patient, who was 14 weeks pregnant, 90 miles by ambulance to another hospital to treat a miscarriage already in progress – the patient's membranes had already ruptured and her health was at risk. Id.

conforming patients. And secure a commitment that LGBTQ+ employees and their families are entitled to the same benefits as all other employees.

4. Require a robust **anti-discrimination provision** ensuring that if a facility provides a specific medical procedure, that procedure will be available to all patients on an equal basis. Procedures must be medically defined and align with evidence-based standards of care.
5. Require the availability of the full spectrum of end-of-life care options and maintain such care. Require that hospitals and nursing homes honor patients' health care proxies and **advanced directives** or disclose in advance any restrictions on honoring the patient's wishes. When a patient's wishes conflict with hospital policy, the hospital or nursing home should be prepared to arrange a transfer to an alternative facility that is located within a reasonable geographic distance and will accept the patient's health insurance coverage.
6. Require specific reporting on maintenance of reproductive health services, essential health services, community benefits, charity care, and Medicaid and Medicare contracts, at a minimum of every three years post-merger.
7. Protect patients' rights to **informed consent**, made with knowledge of all potential treatment options (including those prohibited by a health provider due to religious policies). And require advance **disclosure** to patients of any religiously-based policies that restrict patients' access to medical information or services at hospitals, health systems and clinics, or in the coverage offered by health insurers.
8. Require provision of needed services in cases of **emergency** or when no alternative provider exists, even if the service conflicts with institutional religious doctrine.
9. Require timely **referrals** to alternate providers for non-emergency care when institutional religious policies forbid the provision of needed services.

We look forward to a response.

Sincerely,

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