RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

RACP submission - Religious Freedom Bill

Second Exposure Draft

January 2020

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to provide a submission on the Second Exposure Draft of the Religious Freedom Bils. However, we are concerned that the timeframe for submissions on this proposed Bill has been inadequate to consider a complex Bill such as this, including its interactions with other legislation and codes of conduct, as well as other potential unintended consequences. Once the Bill is introduced to Parliament, the College calls on the Government to facilitate a Parliamentary inquiry with adequate time to enable comprehensive consultation process with key stakeholders and the public via both submissions and public hearings.

About the RACP

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Our submission

The RACP does not support the Second Exposure Draft of the proposed Religious Discrimination Bill for the reasons outlined in this submission. It is our view that:

- Discrimination against patients based on gender identity, gender expression, sexuality, sexual health, pregnancy, health, mental health, race and religion is harmful to patients and is never acceptable.
- Expressing personal and religious views to patients that are likely to be perceived by the patient as judgmental with regard to legal expressions of gender identity, gender expression, sexuality, sexual health, pregnancy, health, mental health, race and religion are always harmful and can be very damaging.
- Directly or indirectly, by act or omission, affecting a patient's access to any legal and/or medically recommended health care service based on a practitioner's views or beliefs with regard to legal expressions of gender identity, gender expression, sexuality, sexual health, pregnancy, health, mental health, race and religion is never acceptable.
- Discrimination against health care workers based on legal expressions of gender, sexuality, sexual health, pregnancy, health, mental health, race and religion is never acceptable.

As outlined in the Second Exposure Draft of the Religious Discrimination Bill 2019, the objects of the Act are to: (1) eliminate, so far as possible, discrimination on the ground of religious belief or activity in a range of areas of public life; (2) ensure as far as practicable, that everyone has the same rights to equality before the law, regardless of religious beliefs or activity and (3) ensure that people can, consistently with Australia's obligations with respect to freedom of religion and freedom of expression, and subject to specified limits, make statements of belief.

There is significant research evidence to describe the negative impact on health of discrimination, and as doctors we see it often in our practice. As such, the RACP strongly supports the protection of individuals against both direct and indirect discrimination based on age, disability, race, gender, gender identity, sexual orientation and religion and believes that federal anti-discrimination law should provide fair and balanced protections to all people on these bases. We also believe that a doctor's first responsibility is the care of the patient. This is a long-standing foundation of medical practice both in Australia and internationally which is reflected in the Medical Board of Australia's

Code of Conduct. In our view, this Bill creates a tension between a doctor's responsibility to their patient, and their own religious beliefs that puts at risk patients' health outcomes.

As a medical college, we are particularly interested to provide feedback on Subclauses 8(6) and (7), Subclauses 32(8) and (10) and Subclause 42 as these Subclauses would impact on physicians' current medical practice and patient care.

Feedback on Subclauses 8(6) and (7)

Subclauses 8(6) and (7) outline conditions under which health professionals have a right to conscientiously object to providing or participating in a particular kind of health service on the basis of their religious belief or activity and specify that the objection must be to a procedure, not to particular people or groups of people.

Subclause 8(6) of the proposed Bill states that "For the purposes of paragraph (1)(c), if a law of a State or Territory allows a health practitioner to conscientiously object to providing or participating in a particular kind of health service because of a religious belief or activity held or engaged in by the health practitioner, a health practitioner conduct rule that is not consistent with that law is not reasonable" and Subclause 8(7) states that "For the purposes of paragraph (1)(c), if subsection (6) does not apply, a health practitioner conduct rule is not reasonable unless compliance with the rule is necessary to avoid an unjustifiable adverse impact on: (a) the ability of the person imposing, or proposing to impose, the rule to provide the health service; or (b) the health of any person who would otherwise be provided with the health service by the health practitioner."

The Bill's Explanatory Notes (paragraphs 184-186) outlines that 'unjustifiable adverse impact' would include "emergency or other critical situations when patient health outcomes are clearly at risk" and that "it is not intended that this provision would allow health practitioners to exercise their conscientious objection in a manner which directly affects the patient, causes disruption to patient care or intentionally impedes patients' access to care". The Explanatory Notes provides the following examples to illustrate these points:

- "if non-compliance with a particular health practitioner conduct rule could result in the death or serious injury of the person seeking the health service, this would clearly amount to an unjustifiable adverse impact."
- "Non-compliance with a policy that required the sole medical practitioner in a small rural community to prescribe contraception in appropriate cases may amount to an unjustifiable adverse impact on the ability of that medical practice to provide medical services to that community, and made also have an unjustifiable adverse impact on the health of women seeking contraception (for example, women seeking the Pill for non-contraceptive use, such as in order to treat endometriosis or polycystic ovary syndrome), as they may be unable to access alternative healthcare promptly without significant travel and cost".

Paragraph 171 of the Bills' Explanatory Notes specifies that "examples of health practitioner conduct rules may include rules which require doctors, nurses, midwives or psychologists to undertake procedures, or provide information, prescriptions, or referrals, related to services such as abortion, euthanasia, contraception or sterilisation, regardless of their religious conscientious objections to those services."

It is problematic for this proposed Bill to refer to health services such as abortion and sterilisation alongside voluntary assisted dying in relation to conscientious objection. The status of voluntary assisted dying in current legislation is more complex than the proposed Bill allows. For example, in Victoria, voluntary assisted dying is judged to be legal, however, patients do not have a right to access it and clinicians have no obligation to even discuss it or advise patients that it may be possible which is something that does not apply to any other legal medical intervention. The situation with regard to voluntary assisted dying including doctors' responsibility to inform patients

about voluntary assisted dying even where the clinician has no intention of being involved or even referring them to another practitioner is a matter of ongoing discussion and debate in state jurisdictions.

Conscientious objection in current medical practice

Doctors have ethical and professional obligations to patients, and an ability to conscientiously object to providing certain health services already forms part of current medical practice. The RACP's position on conscientious objection is that doctors who conscientiously object to providing certain health services should not impede patient access to treatments that are legal, and that they should refer their patients to alternative health professionals where required. However, for the provision of voluntary assisted dying, the RACP acknowledges that "the moral impact of referring a request for voluntary assisted dying to a willing practitioner may be felt deeply" and "holds that physicians should not be forced to refer, but neither should they hinder patients from accessing such services."[1] The RACP believes that "although physicians should not be forced to act outside their values and beliefs, they also should not disengage from patients holding different values and beliefs, without ensuring that arrangements for ongoing care are in place."[2]

The RACP's position on conscientious objection aligns with that of the Medical Board of Australia's (MBA) *Good medical practice: a code of conduct for doctors in Australia*[3] and the Australian Medical Association's (AMA) *position statement on conscientious objection*[4] which both highlight that medical practitioners have a duty to prioritise the care of patients, to minimise disruption to patient care and to never use their conscientious objection to intentionally impede patients' access to care.

The MBA's Code of Conduct[5] "describes what is expected of all doctors registered to practice medicine in Australia" and "sets out the principles that characterise good medical conduct expected of doctors by their professional peers and the community". This code recognises that doctors are free to decline to personally provide or participate in care that they conscientiously object to but that they should not allow their moral or religious views to deny patients access to medical care. It further states that doctors should avoid expressing their personal beliefs to their patients in ways that exploit the vulnerability of these patients or are likely to cause them distress. Doctors are held in high regard by the community and it is acknowledged that there can be a power imbalance in the doctor-patient relationship. Value judgements of patients, even if they reflect sincerely-held beliefs, can cause long-lasting trauma for patients and should not be encouraged in our view.

The AMA defines conscientious objection as "occurring when a doctor, as a result of a conflict with his or her own personal beliefs or values, refuses to provide, or participate in, a legal, legitimate treatment or procedure which would be deemed medically appropriate in the circumstances under professional standards"; conscientious objection is "based on sincerely-held beliefs and moral concerns, not self-interest or discrimination".[6] Importantly, as outlined in the AMA's submission to the First Draft Exposure Bill[7], "conscientious objection can occur not just in relation to religious beliefs but also personal moral or ethical concerns. In addition, a very important feature of conscientious objection is it should be based on an individual's deeply held (often long-term) personal beliefs. This is important as not every individual who identifies with a particular religion will necessarily have the same level of conviction in relation to a particular belief or doctrine of that religion (for example, a particular religion may oppose abortion, contraception or same-sex marriage but may have members who do not oppose these activities)."

[1] The Royal Australasian College of Physicians (RACP) (2018), Statement on Voluntary Assisted Dying, p.27
[2] The Royal Australasian College of Physicians (RACP) (2018), Statement on Voluntary Assisted Dying, p.2
[3] Medical Board of Australia (MBA) (2014), Good medical practice: a code of conduct for doctors in Australia
[4] The Australian Medical Association (AMA) (2019), Position Statement on Conscientious Objection
[5] Medical Board of Australia (MBA) (2014), Good medical practice: a code of conduct for doctors in Australia
[6] The Australian Medical Association (AMA) (2019), Position Statement on Conscientious Objection
[7] Australian Medical Association (AMA) (2019), Submission to the Exposure Draft Religious Discrimination Bill 2019.

In short, it is important to recognise that the medical profession has considered conscientious objection deeply and carefully over many centuries to achieve the right balance between providing health care on a fair and equitable basis and allowing health professionals to express their sincerely held personal beliefs. We believe this Bill would undermine that balance and could lead to worse patient outcomes.

Our concerns with the way in which conscientious objection is characterised in the Bill and its potential negative impacts on patients

As it stands, the proposed Bill would in effect provide health professionals with greater protection for conscientious objection on religious grounds than for conscientious objections based on other personal or moral beliefs. This runs contrary to the way in which conscientious objection is currently understood and applied in medical practice and does not appropriately reflect the value of non-religious ethical and moral beliefs to individual practitioners nor their right to conscientious objection as it currently stands.

The proposed Bill could also undermine the current professional bodies' existing codes of practice which, as outlined in the AMA's submission to the First Exposure draft, "may cause serious confusion in the real world where doctors will not know, in their daily work at the coalface, whether to rely on legislation or professional standards, potentially leading to as yet unclear, and possibly adverse, patient outcomes."[8]

The RACP does not believe that the proposed Bill provides the appropriate balance between a health professional's right to conscientiously object to providing certain health services on religious grounds and their professional responsibility to prioritise patient care by ensuring patients are afforded safe and timely access to healthcare. The proposed Bill does not safeguard patients' safe and timely access to legal health services in instances where their health professionals conscientiously object to providing them based on their religious belief or activity.

As stated in the AMA's submission to the First Exposure Draft, "If applied inappropriately without being balanced against this duty to the patient, a doctor's right to conscientious objection could have significant negative and harmful impacts on individuals' access to health care. In particular, individuals that already face stigma and uncertainty when trying to access particular health services (as highlighted previously, examples include LGBTIQ people, individuals from culturally and linguistically diverse backgrounds, asylum seekers and refugees, women, young people, individuals with mental health issues) as well as those for whom access to services may be logistically challenging (for example, individuals with disabilities, the elderly, those living in rural and remote areas)."

In addition, given that conscientious objection already forms an integral part of current medical practice, and is recognised in the established codes of professional conduct from the MBA and the AMA and other medical organisations, it is unclear why Subclauses 8(6) and (7) are required and which issues this Bils is seeking to address in this specific area of current medical practice. Any legislation which refers to conscientious objection for doctors should support relevant professional bodies' existing codes of practice. We would therefore recommend removing Subclauses 8(6) and (7) from the legislation.

Feedback on Subclauses 32(8) and (10)

Subclauses 32(8) and (10) would enable religious hospitals, aged care facilities and accommodation providers to 'maintain their religious ethos through staffing decisions'. In effect, these subclauses

[8] Australian Medical Association (AMA) (2019), Submission to the Exposure Draft Religious Discrimination Bill 2019.

open the possibility that religious hospitals (both public and private) will be allowed to discriminate against staff, including doctors, of different or no faiths from being employed or given clinical privileges.

The primary determinants of a doctor's suitability for employment in any healthcare organisation, aged care facility or other facility which employs medical professionals should be their education, training, continuing professional development (CPD), experience and ability to provide high quality patient care within their scope of practice.

As drafted, these subclauses run the risk of impacting patient care and fail to acknowledge that whilst it is reasonable for these institutions to require that doctors and other staff they employ practice in accordance with institutional ethics, religious identity is only one possible measure of one's ethical position.

Our members also raised the issue that in geographic areas of high cultural and linguistic diversity where religious hospitals and aged care facilities are allowed to "maintain their religious ethos through staffing decisions", there could be flow on effects to the groups of clients that would seek admission, effectively excluding them from care and treatment in these facilities. Patients may need to discuss sensitive issues with their doctor, and in this context patients with specialised religious, cultural and language needs often find it more comfortable and more effectively engage in their care when at least some of the treatment providers and carers share their culture. This aspect of the Bill has the potential to create facilities that preferentially treat patients with similar beliefs, which runs counter to the ethical requirement to treat all patient similarly irrespective of cultural differences.

Feedback on Clause 42

We also have some concerns regarding Clause 42 which aims to protect statements of beliefs that are made in good faith from the operation of certain provisions of Commonwealth, state and territory anti-discrimination law. As it stands, Clause 42 would enable health professionals to express personal views to patients based on their religious belief or activity as long as they are made 'in good faith' even though these views could cause patients distress and lead to negative consequences on their health and wellbeing as well as their access to healthcare.

Paragraph 549 of the Bill's Explanatory Notes provides the following example: "a statement by a doctor to a transgender patient of their religious belief that God made men and women in his image and that gender is therefore binary may be a statement of belief, provided it is made in good faith." We already know that accessing healthcare is difficult for many vulnerable and disadvantaged patients including LGBTI Australians and we are concerned that this proposed Bill would exacerbate these issues by enabling doctors and other health professionals to make statements of beliefs (in good faith) with little regard as to whether these statements could cause distress to their patients and impede their access to healthcare. As stated in section 1.4 of the MBA Code of Conduct,[9] "doctors have a duty to make the care of patients their first concern and to practice medicine safely and effectively" and section 8.2 outlines that doctors should avoid expressing their personal beliefs to their patients in ways that exploit their vulnerability or are likely to cause them distress.

Patients' access to care can be impeded and patients can be harmed through a clinician's speech, attitudes, views and culture. While religious views must always be accorded respect, in doing so we must ensure that this does not create harm or reverse the protections that have been put in place to protect patients including professionals' codes of conduct. We are concerned that Clause 42 would undermine doctors' ethical and professional obligations to their patients in this regard.

[9] Medical Board of Australia (2014), Good medical practice: a code of conduct for doctors in Australia

Conclusion

The RACP does not support the Second Exposure Draft of the proposed Religious Discrimination Bill for the reasons outlined in this submission.

As previously stated, there is significant research evidence to describe the negative impact on health of discrimination, and as doctors we see it often in our practice. The RACP strongly supports the protection of individuals against both direct and indirect discrimination based on age, disability, race, gender, gender identity, sexual orientation and religion and believes that federal anti-discrimination law should provide fair and balanced protections to all people on these bases. Any legislation seeking to protect individuals against both direct and indirect discrimination based on religion must be consistent with all existing anti-discrimination legislation.

Thank you again for this opportunity to provide the RACP's feedback on the Second Exposure Draft of the Religious Freedom Bill Should you require further information about this submission, please contact the RACP Policy & Advocacy Unit on Policy@racp.edu.au.