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Freedom of Religion Consultations
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Dear Freedom of Religion Consultation

Thank you for providing the Australian Medical Association (AMA) with the opportunity to make a submission on the *Exposure Draft Religious Discrimination Bill 2019*. The AMA is a medico-political organisation representing Australia's medical practitioners and medical students. While the AMA exists to promote and protect the professional interests of doctors, we also advocate for the health care needs of patients and communities. An essential aspect of this advocacy is to ensure that all patients have appropriate access to medical care.

We would like to raise both general and specific comments in relation to the Freedom of Religion Consultation and to the Bill itself.

Timeframe for consultation

The timeframe for providing submissions on the Bill is inadequate and should be extended. It currently limits the opportunity for organisations such as the AMA and others to be able to appropriately consult with their own members on such an important issue. The *Religious Discrimination Bill 2019* has the potential to impact both positively and negatively on individuals, employers and the wider community. Sufficient time should be afforded for interested parties to thoroughly scrutinise the draft legislation, determine the potential impact on themselves and others and prepare an informed submission.

Interaction with other anti-discrimination laws

It is not clear how the Bill will interact with other anti-discrimination laws. It is essential that the provisions in any religious discrimination bill complement, and not undermine or override, these existing anti-discrimination laws; otherwise, there is potential to further marginalise particular groups of individuals that may already face stigma and uncertainty when trying to access health care or particular health services (for example, LGBTIQ people, individuals from culturally and linguistically diverse backgrounds, asylum seekers and refugees, women, young people, individuals with mental health issues).

Should this Bill be enacted, it will be essential that health professionals and the wider community be appropriately informed as to how religious discrimination legislation interacts with current anti-discrimination legislation.

AMA position on conscientious objection

In accordance with the World Medical Association's *Declaration of Lisbon on the Rights of the Patient*, every person is entitled without discrimination to appropriate health care. As such, it is essential to ensure that the enjoyment of religious freedom does not undermine the right to health care.

In accordance with the AMA's *Code of Ethics 2016*, doctors (medical practitioners) have an ethical and professional duty to provide care impartially and without discrimination on the basis of age, disease or disability, creed, religion, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, criminal history, social standing or any other similar criteria.

Doctors are entitled to have their own personal beliefs and values as are all members of the community. The AMA believes it is acceptable for a doctor to refuse to provide or to participate in certain medical treatments or procedures based on a conscientious objection; however, there must be an appropriate balance between the rights of doctors to conscientious objection with the rights of individuals to access and receive appropriate health care.

Definition of conscientious objection

It is notable that the Bill does not appear to define conscientious objection. Paragraph 134 of the Explanatory Notes simply states that:

A 'health practitioner conduct rule', for the purposes of the Act, applies solely to conscientious objections based on beliefs that may reasonably be regarded as being in accordance with the doctrines, tenets, beliefs or teachings of the practitioner's religion.

It is important to acknowledge that 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).

In accordance with the AMA's *Position Statement on Conscientious Objection 2019*, a conscientious objection occurs 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. A conscientious objection is based on

sincerely-held beliefs and moral concerns, not self-interest or discrimination. A refusal by a doctor to provide, or participate in, a treatment or procedure for legitimate medical or legal reasons, does not constitute a conscientious objection.

The primacy of patient care and the limits to conscientious objection by doctors

Any legislation that addresses conscientious objection by doctors must reflect and uphold the ethical and professional standards of the medical profession where the doctor's primary duty is to support the health needs of patients. 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).

While recognising the intent of the *Religious Discrimination Bill 2019* to allow for health care practitioners to conscientiously object to providing a health service because of a religious belief or activity, as written, subclauses 8(5) and 8(6) are ambiguous and unclear and do not recognise that doctors who conscientiously object to providing specific medical services still have ethical and professional obligations to patients and others who may be directly affected.

Subclause 8(6) attempts to set a threshold by which a doctor's conscientious objection to providing a particular medical service should take precedence over the patient's right to receive that service. Subclause 8(6) qualifies the right of a health practitioner to conscientiously object to providing a health service *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.*

We have particular concern that an 'unjustifiable adverse impact' is not defined, making it ambiguous and largely open to interpretation. While Paragraphs 147 and 148 of the Explanatory Notes provide relevant examples of an unacceptable adverse impact – for example, the death or serious injury of the person seeking the health service (Paragraph 147) and the potential inability of women seeking contraception in a small rural community to access alternative healthcare promptly without significant travel and cost (Paragraph 148) – there are a wide range of circumstances left open for interpretation. Importantly, the opinions of the objecting doctor, the health facility and patients as to what constitutes an 'unjustifiable adverse impact' on them in relation to seeking any form of health care are likely to be very different.

Should this Bill become legislation, it is absolutely essential that the medical profession and the wider community be consulted to develop and promote guidance on how the proposed legislative definitions and limits (in particular ‘unjustifiable adverse impact’) of conscientious objection on religious grounds relate to current definitions of conscientious objection under professional standards and the greater responsibility to consider a duty to the patient that exist under these standards.

A doctor’s duty to minimise disruption to patient care

In its policy on conscientious objection the AMA strongly advocates that a doctor’s refusal to provide or participate in certain medical treatments or procedures based on conscientious objection directly affects patients and they have an ethical obligation to minimise disruption to patient care. In such circumstances, a doctor:

-) should never use a conscientious objection to intentionally impede patients’ access to care;
-) should always provide medically appropriate treatment in an emergency situation, even if that treatment conflicts with their personal beliefs and values;
-) should make every effort in a timely manner to minimise the disruption in the delivery of health care and ensuing burden on colleagues and other health care professionals;
-) inform the patient of their objection, preferably in advance or as soon as practicable;
-) inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right;
-) take whatever steps are necessary to ensure the patient’s access to care is not impeded;
-) continue to treat the patient with dignity and respect, even if the doctor objects to the treatment or procedure the patient is seeking;
-) continue to provide other care to the patient, if they wish;
-) refrain from expressing their own personal beliefs to the patient in a way that may cause them distress;
-) inform their employer, or prospective employer, of their conscientious objection and discuss with their employer how they can practice in accordance with their beliefs without compromising patient care or placing a burden on their colleagues.

This guidance strikes a reasonable balance between a doctor’s right to conscientious objection and the right of patients to access health care while also minimising any adverse effects on the doctor’s colleagues and employer.

Professional codes of conduct

In addition, in those circumstances where it is considered acceptable for a doctor to conscientiously object to providing a medical service, the doctor nonetheless has ethical and professional obligations to the patients directly affected by that decision which are

not reflected in the draft legislation. For example, the Medical Board of Australia's *Code of Conduct for Doctors in Australia: Good Medical Practice*, the Code by which all registered medical practitioners must abide, states the following in relation to conscientious objection:

Good Medical Practice involves:

2.4.6 Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.

2.4.7 Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.

If a medical facility requires doctors to abide by these professional obligations as determined by the Medical Board of Australia, would they be in breach of the draft legislation? This is not clear and legislation that conflicts with definitions and thresholds promoted in professional standards 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.

And what about other government and professional codes of conduct and policies relevant to conscientious objection by doctors? Medical facilities should be able to promote government and professional codes, guidelines and policies for doctors that provide an appropriate balance between supporting a doctor's right to conscientious objection while ensuring patients right to safe, accessible health care.

Summary of recommendations

In relation to the *Exposure Draft Religious Discrimination Bill 2019*, the AMA makes the following recommendations:

- 1) Extend the timeframe for accepting submissions to allow individuals and organisations sufficient time to consult with their members and others (as relevant) and prepare well-informed submissions;
- 2) Ensure religious discrimination legislation complements, and does not undermine or override, existing anti-discrimination legislation;
- 3) In consultation with the medical profession, amend the Bill to support (and not conflict with) the profession's ethical and professional standards as they relate to conscientious objection. Ethical and professional standards recognise that doctors' conscientious objections directly affect patients and doctors have an obligation to minimise disruption to patient care. This requires the following amendments to the Bill:

-) Either define conscientious objection in line with, or refer to, current definitions held by the medical profession such that a conscientious objection is based on an individual's deeply held (and often long-term) beliefs and moral concerns (which may or may not have a religious basis), not self-interest or discrimination;
-) Ensure the Bill strikes a reasonable balance between the rights of a doctor (and other health professionals) to conscientious objection and the rights of patients to access health care, ensuring legislative limits to conscientious objection are consistent with ethical and professional standards. Alternatively, refer in legislation to current professional standards with respect to the responsibilities of doctors should they conscientiously object on religious grounds.

4) Should specific legislation on religious discrimination be enacted in the future, doctors, other health professionals and the wider community must be appropriately informed as to how such legislation interacts with current anti-discrimination legislation and how it potentially affects the provision of health care.

While the AMA recognises the exercise of religious freedom is important to society, the right to health care is equally upheld. We must all work to ensure these values are appropriately balanced for the benefit of all Australians.

Sincerely

Dr Tony Bartone
President

1 October 2019