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AMA Submission on the *Second Exposure Draft of the Religious Discrimination Bill 2019*

Attention Freedom of Religion Consultation
FoRConsultation@ag.gov.au

Thank you for providing the Australian Medical Association (AMA) with the opportunity to make a submission on the *Second Exposure Draft of the Religious Discrimination Bill 2019.* The AMA is a medico-political organisation representing Australia's doctors (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.

The AMA finds that sections of the Bill not only fail to reflect or support the well-developed framework of professional standards of the medical profession, but they also appear to override these standards and create a new confusing element with the potential for serious unintended consequences. In potentially upsetting the fine balance that existing professional standards impose on doctors regarding their rights and responsibilities, the Bill appears to reduce patient safeguards and derogate patients' rights to access health care, while also undermining the rights of some doctors by enabling employers to discriminate against them based on religious belief.

The AMA believes that for doctors, who are bound by a framework of professional standards, this proposed legislation is unnecessary and may only ultimately act to create problems which have not previously existed, with the real potential for adverse impacts on patient care.

The AMA will largely focus its submission on two areas specifically targeted at health practitioners; namely, Section 8, subclauses 8(6) and 8(7) that relate to conscientious objection by health practitioners and Section 32 addressing exceptions relating to work and, specifically, subclauses 32(8)-(12) that allow religious hospitals and aged care facilities to take faith into account in staffing decisions.

While the *Second Exposure Draft of the Religious Discrimination Bill 2019* relates to a range of health practitioners, the AMA's submission focusses on the medical profession.

GENERAL COMMENTS

Timeframe for consultation

In our submission on the first exposure draft of the Bill, we stated that the timeframe for providing submissions was inadequate and should be extended to allow individuals and organisations sufficient time to consult with their members and others on such an important issue. It is disconcerting, therefore, that the timeframe for providing submissions on the second exposure draft of the Bill is only slightly longer in length but also held over the summer holiday time-period when many Australians are away from their homes and from the workplace.

This effectively undermines the opportunity for individuals and organisations to thoroughly scrutinise and understand the legislation, identify the potential implications of the legislation for themselves and their own constituents (eg, AMA members) and adequately prepare these submissions. Providing sufficient time for consultation ensures the legislators are fully informed of the concerns, implications and potential consequences of this legislation for the Australian public, allowing them to make informed decisions when undergoing the next step in the legislative process.

We therefore recommend that the timeframe for providing submissions on the Bill be extended.

Interaction with other anti-discrimination laws

We reiterate from our previous submission that it is still not clear how the Bill will interact with other anti-discrimination laws as well as same-sex marriage legislation. It is essential that the provisions in any religious discrimination bill complement, and do 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, we recommend that health practitioners and the wider community be appropriately informed as to how religious discrimination legislation interacts with current anti-discrimination legislation.

Interaction with professional standards, codes and guidelines

In Australia, doctors must adhere to a wide range of medical professional standards, codes and guidelines produced by professional regulatory authorities such as the

Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia. AHPRA supports the Medical Board, which is responsible for regulating the medical profession, in protecting the public (AHPRA also supports the Boards of the other registered health practitioners). In addition to the regulatory authorities such as AHPRA and the Medical Board, the Australian Medical Association, the Australian medical colleges, relevant government departments of health and agencies and other organisations also develop their own policies, codes and guidelines consistent with medical professional standards.

The Medical Board's Code of Conduct, *Good Medical Practice: A Code of Conduct for Doctors in Australia,* sets out the principles of good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors registered to practice medicine in Australia by their professional peers and the community. Doctors have a professional responsibility to be familiar with the Code of Conduct which will be used by the Medical Board:

- *to support individual doctors in the challenging task of providing good medical care and fulfilling their professional roles, and to provide a framework to guide professional judgement;*
- *to assist the Medical Board of Australia in its role of protecting the public, by setting and maintaining standards of medical practice against which a doctor's professional conduct can be evaluated;*
- *as an additional resource for a range of uses that contribute to enhancing the culture of medical professionalism in the Australian health system; for example, in medical education; orientation, induction and supervision of junior doctors and international medical graduates; and by administrators and policy makers in hospitals, health services and other institutions.*

The Code of Conduct sets out the professional values and qualities of doctors expected by the community. It articulates that while individual doctors have their own personal beliefs and values, there are certain professional values on which all doctors are expected to base their practice, most importantly that:

Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy.

The Code emphasises that patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion.

It is important to recognise that there is a potential power imbalance in the doctor-patient relationship. While doctors have the highly specialised knowledge and skills patients require to obtain good quality health care, patients may feel vulnerable or

are potentially vulnerable and exposed due to the very personal and physical nature of the doctor-patient relationship.

It is therefore essential that the public have a high level of trust and confidence in the medical profession. If people do not trust doctors, they will seek care elsewhere, or not seek care at all, either of which may prove detrimental to the health and well-being of individuals as well as the wider public health.

Standards of professional behaviour such as the Code of Conduct reflect community expectations of the medical profession. They are generally developed in conjunction with the profession itself and the wider community. They reflect the codes of ethics accepted by the medical profession in Australia including the AMA's own *Code of Ethics* and those of Australian medical colleges and international medical associations such as the World Medical Association.

It is essential, therefore, that any Commonwealth, State or Territory legislation relevant to doctors reflect and support these professional standards, not undermine or override them. The AMA considers specific sections of the *Second Exposure Draft of the Religious Discrimination Bill 2019* do not reflect and uphold professional standards (as addressed below).

In addition, it appears that the Bill (if passed) would actually override these standards in the absence of relevant State or Territory legislation (for example, in relation to conscientious objection by doctors). This would create a conflict between professional standards and Commonwealth legislation where relevant sections of the Code of Conduct are simply displaced by the legislation, effectively undermining the role of the Medical Board and the ethical codes of the wider medical profession.

This could create confusion for doctors who must consider whether to act consistent with their professional standards (to which they must adhere to maintain their professional registration) but contrary to the law (potentially placing them at risk of a complaint for breaching religious discrimination legislation) or consistent with the law but contrary to their professional standards (potentially placing them at risk of a complaint to the professional regulator for breaching professional standards).

Legislation that conflicts with 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.

It is essential, therefore, that any Commonwealth, State or Territory legislation that impacts on doctors reflects and upholds, and does not undermine or override, professional standards.

SPECIFIC COMMENTS

SECTION 8 – Discrimination on the ground of religious belief or activity – indirect discrimination

Conditions that are not reasonable relating to statements of belief (subclauses 8(3)-(5)

According to the Bill, private employers generating at least $50 million in annual revenue are prohibited from imposing an "employer conduct rule" (eg. policy) that prevents an employee from making a statement of belief outside of work. Such a policy would be found unreasonable and discriminatory and not capable of being an inherent requirement of employment (other than when a policy rule is shown to be required to prevent "unjustifiable financial hardship" – arguably a very high onus).

This lawfully enables statements (asserted to be based on religious belief) to offend, humiliate, insult or intimidate groups such as women, LGBTIQ people or persons with disabilities. The prohibition is only waived where the statement of belief is malicious, or would harass, vilify, or incite hatred towards another person or group of persons, or would encourage conduct constituting a serious offence. This very high threshold leaves extensive scope for bullying, harassment and intimidation of people or groups of people - again such as women, LGBTIQ people and persons with disabilities (to name a few) - that can lead to serious risk of harm to individuals' health and well-being.

This particular provision of the Bill, therefore, conflicts with professional standards and guidance set by AHPRA. For example, the AHPRA has developed guidelines for registered health practitioners including doctors entitled *Social Media: How to Meet your Obligations under the National Law*. These guidelines clarify that doctors should be mindful when using social media, even in a private capacity, as the Medical Board could consider such use if it raises concerns over a doctor's fitness to hold registration. Relevant excerpts from the guidelines include the following:

Inappropriate use of social media can result in harm to patients and the profession, particularly given the changing nature of privacy and the capacity for material to be posted by others. Harm may include breaches of confidentiality, defamation of colleagues or employers, violation of practitioner–patient boundaries or an unintended exposure of personal information to the public, employers, consumers and others. Information stays on social media indefinitely. Information published on social media is often impossible to remove or change and can be circulated widely, easily and rapidly. Therefore, it's important that you are very careful about what you like or post online- regardless of where in the world the site is based or the language used.

Where relevant, National Boards may consider social media use in your private life (even where there is no identifiable link to you as a registered health practitioner) if it raises concerns about your fitness to hold registration. While you may think you are engaging in social media in a private capacity because you do not state you are a registered practitioner, it is relatively easy and simple for anyone to check your status through the register, or make connections using available pieces of information.

The AHPRA guidelines provide specific examples when a doctor's activity on social media could trigger someone to make a notification about them. The following is an example provided under the banner of 'cultural awareness, safety and practitioner and patients beliefs – social and clinical':

As a registered health practitioner, your views on clinical issues are influential. Comments in social media that reflect or promote personal views about social and clinical issues might impact on someone's sense of cultural safety or could lead to a patient/client feeling judged, intimidated or embarrassed.

EXAMPLE 1

A health practitioner, who works in a small town makes their religious views about sex before marriage and homosexuality public by tweeting: 'Abstinence is the best way to avoid HIV. Not sure why we are investing public dollars into developing vaccines. Just do what the bible tells us to do'. A patient sees this and now feels concerned they cannot reveal their sexuality to the practitioner, thereby compromising their health and safety. They make a notification about discrimination.

In its own guidelines entitled *Guide to Social Media & Medical Professionalism 2019,* the AMA supports the view that, no matter what happens privately, a doctor is always a doctor and needs to consider how they present themselves as their professional character may be judged by the way they conduct themselves online.

Using this social media example, the provisions in the Bill do not necessarily guarantee the application of AHPRA's professional standards were a doctor to speak publicly in a private capacity. A doctor could be subject to a notification under AHPRA should they act in a way inconsistent with standards set by AHPRA and the Medical Board. Currently, such a notification could have potential employment implications for the doctor including possible dismissal; however, under the Bill the doctor would be protected from such dismissal even though they breached their professional standards. This effectively makes rules set by AHPRA and the Medical Board secondary to the Bill.

Even where express employment terms were not perceivably breached, a breach of AHPRA or the Medical Board rules would, in normal circumstances warrant an employer act to validly terminate (or discipline). Contrary to that, a "religious body" could

undermine these professional standards by instead seeing no reason to manage the doctor because of its "religious ethos".

Conditions that are not reasonable relating to conscientious objections by health practitioners (subclauses 8(6) and 8(7))

The AMA acknowledges that the second exposure draft of the Bill now provides a definition of conscientious objection (in section 5), the absence of which was raised in our previous submission, noting that the definition states that a conscientious objection:

- relates to providing or participating in a particular kind of health service (and not to the personal attributes of the person seeking the service); and
- occurs only where a person of the same religion as the health practitioner could reasonably consider the refusal to provide or participate in that kind of health service as being in accordance with the doctrines, tenets, beliefs or teachings of that religion.

Notwithstanding the addition of a definition in the second exposure draft of the Bill, clauses 8(6) and 8(7) (conditions that are not reasonable relating to conscientious objection by health practitioners) continue to:

- fail to achieve an appropriate balance between doctors' right to conscientious objection and patients' right to access health care and be treated impartially and without discrimination; and
- undermine professional standards and ethics as they relate to a doctor's duty to patients when refusing to provide or participate in a service due to conscientious objection.

Subclause 8(7)(b) states that a health practitioner conduct rule is not reasonable unless compliance with the rule is necessary to avoid an unjustifiable impact on:

(b) the health of any person who would otherwise be provided with the health service by the health practitioner.

Health care in Australia is patient-centred, recognising that each person is unique, and what constitutes an 'unjustifiable adverse impact' on the health of an individual is primarily determined by that person themselves. Any legislation that incorporates conscientious objection by doctors must reflect and uphold the ethical codes and professional standards of the medical profession where the doctor's primary duty is to support the health needs of patients. If applied inappropriately, a doctor's refusal to provide a particular health service due to conscientious objection could result in an unjustifiable adverse impact on the physical and mental health of the person seeking care as primarily determined by that person.

Examples of how a doctor's conscientious objection can adversely impact on a patient include the following:

- There may be a direct adverse effect on the person's health from not receiving the specific care at the time it is sought. In some situations, a delay in accessing services can increase adverse health outcomes, particularly where the need to receive treatment is time critical (for example, in terms of abortion or post-exposure prophylaxis);
- There may be an indirect effect on the person's health if the logistics of seeking care elsewhere delays treatment. This includes the time it takes to find a practitioner willing to provide the requested service, the time and costs associated with additional travel as well as the potential for accommodation and other related costs as well (for example, taking time off work to travel). Additional travel also may prove physically challenging, particularly for those with disabilities, the elderly and those living in rural and remote areas;
- There may also be an adverse effect on the person's mental health where the person feels confused, stigmatised and/or discriminated against by the doctor. They may delay or even forego seeking further care because of this, putting the person at greater health risk;
- In some cases, due to the very real fear of being judged, stigmatised or refused care, some patients may not provide their doctor with full or accurate health and lifestyle information. This can result in a doctor making treatment recommendations based on insufficient or inaccurate information, risking adverse patient health outcomes;
- Some people (or groups of people) may forego seeking medical care altogether should their experience (or the experience of others) in relation to a doctor's conscientious objection lead them to mistrust the medical profession more generally.

As written, subclauses 8(6) and 8(7) have the potential to undermine equity of access to services for many, especially those from particularly vulnerable or marginalised groups such as LGBTIQ people, Indigenous Australians, individuals from culturally and linguistically diverse backgrounds, asylum seekers and refugees, women, young people and individuals with mental health conditions.

The Explanatory Notes to the Bill include a new paragraph which states:

184. 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.

By its very nature, refusing to provide a person with the treatment they seek due to a conscientious objection will directly affect that individual. This is why doctors with conscientious objections must take action to minimise the disruption to patient care.

The AMA's *Code of Ethics* advocates that the doctor-patient partnership is based on mutual respect, trust and collaboration, where both doctor and patient have rights as well as responsibilities. While 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, that doctor has a responsibility to minimise any impact on patient care. The AMA's *Position Statement on Conscientious Objection* 2019 provides relevant guidance where doctors should:

- *never use a conscientious objection to intentionally impede patients' access to care;*
- *always provide medically appropriate treatment in an emergency situation, even if that treatment conflicts with their personal beliefs and values;*
- *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.*

In addition to the AMA's *Position Statement on Conscientious Objection 2019*, the AMA's *Position Statement on Ethical Issues in Reproductive Medicine 2019* addresses conscientious objection as it applies to reproductive medicine more broadly and abortion specifically as follows:

1.6 Doctors who have conscientious objections should not be expected to participate in clinical or research activities to which they have an objection. A doctor's refusal to provide, or participate in, a treatment or procedure based on a conscientious objection, however, directly affects patients and the doctor has an obligation to inform the patient of their objection and minimise disruption to patient care. In an urgent situation where

other care is not available (for example, complications of an abortion in a rural area), there is a clear obligation to provide and continue care for the patient until such time as other options are available. Doctors must never use a conscientious objection to intentionally impede patients' access to care.

2.4.1 Doctors hold differing views regarding abortion. Where a doctor has a conscientious objection to abortion, they must inform the patient of their objection and ensure the impact of a delay in treatment does not constitute a significant impediment to the patient accessing services. The doctor must take whatever steps are appropriate to ensure the patient's access to care is not impeded. Due to the time critical nature of abortion services, in some circumstances providing the patient with sufficient information on accessing such services may be sufficient while other situations may require an effective referral to another practitioner.

In addition to the AMA's policies on conscientious objection, the Medical Board's Code of Conduct states that a doctor's decision about patients' access to medical care need to be free from bias and discrimination (Paragraph 2.4). Specific to conscientious objection, Paragraphs 2.4.6 and 2.4.7 of the Code of Conduct states that 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.

Several of the Australian medical colleges also have policies relevant to conscientious objection such as:

1. The Royal Australasian College of Physicians. Circumcision of Infant Males. September 2010

Doctors who have a conscientious objection to performing infant male circumcision should make this known and refer parents to another doctor.

2. The Royal Australasian College of Physicians. Statement on Voluntary Assisted Dying

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.*

3. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Code of Ethical Practice.

Conscience: No doctor or patient shall be compelled to act contrary to moral conviction or religious belief, except as required by law.
2.6 Further opinion / referral: Doctors should offer or arrange a further opinion and/or ongoing care with another suitable practitioner if:

- *the patient requests this;*
- *the therapy required is beyond the individual doctor's expertise or experience;*
- *the therapy required is in conflict with the doctor's personal belief/value system.*

If a doctor wishes to discontinue care of a particular patient, he/she must make appropriate referral and with the patient's consent communicate relevant information to the new practitioner. Doctors should not unreasonably refuse to accept referral or provide care; this applies particularly in an emergency or if no other appropriate practitioner is available.

4. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Position Statement. Abortion. C-Gyn17.

4.6 Workforce: A cornerstone of the provision of good health care is the availability of well-trained health professionals. Issues relating to abortion should be included in the education of all health professionals, particularly those who are primarily involved in women's health care. No member of the health team should be expected to perform abortion against his or her personal convictions, but all have a professional responsibility to inform patients where and how such services can be obtained and to be respectful of the women's decision. A systematic approach is required to ensure recruitment and training of sufficient health professionals to provide safe clinical care.

These policies clearly set out a higher standard of expected professional behaviour than that allowed for in the Bill by upholding doctors' primary duty to patients through supporting patients' access to care and protecting patient safety. Further, the standards set out in the Medical Board's Code of Conduct as well as policies of the AMA and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists recognise the potential workforce implications of doctors with conscientious objections. Doctors with such objections should inform colleagues and others (eg, employers, prospective employers) of their conscientious objections in order to support doctors to practice in accordance with their beliefs without compromising patient care or placing a burden on colleagues and to ensure recruitment and training of sufficient doctors to provide safe clinical care.

We note that the Bill states that the right to conscientious objection should not be limited unless there would an 'unjustifiable adverse impact' on third parties

and that this may arise 'in times of emergency or in other critical situations when patient health outcomes are clearly at risk' (Explanatory Notes, Paragraph 183).

Paragraphs 185 and 186 of the Explanatory Notes attempt to clarify this statement as follows:

185. By way of illustrative example, 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. Other types of risks or impacts to patient health may also amount to unjustifiable adverse impact.

186. By way of further example, 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 may 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.

While it is reassuring that the current draft of the Bill now considers death or serious injury to be an 'unjustifiable adverse impact' (rather than the first exposure draft where death or serious injury would 'generally' amount to an unjustifiable impact as addressed in Paragraph 147 of the Explanatory Notes), this threshold is simply too high and puts patient safety at risk. For many health conditions that are not expected to result in death or serious injury, a delay in accessing treatment or information may nonetheless place that person's physical and/or mental health at serious risk of harm. For example, a delay in undertaking an abortion could lead to a woman having to undertake a surgical rather than medical abortion, resulting in a greater risk of health complications.

When taking account of the issues raised in relation to conscientious objection, the AMA believes that, as written, subclauses 8(6) and 8(7) of the *Second Exposure Draft of the Religious Discrimination Bill 2019* are inconsistent with and undermine professional standards. It is recommended that subclauses 8(6) and 8(7) are either:

- removed from the Bill altogether to allow the medical profession to continue to be guided by professional standards set out by the Medical Board and other relevant regulatory authorities; or,
- if maintaining a section on conscientious objection by doctors, the section is appropriately revised in consultation with the medical profession to ensure they reflect, and do not undermine, professional standards.

32 EXCEPTIONS RELATING TO WORK

Exception – religious hospitals, aged care facilities and accommodation providers may act in accordance with their faith, etc (subclauses 32(8-12))

The Bill authorises the preservation of a religious hospital's or religious aged care facility's *"religious ethos"* in order to enable such entities to discriminate in terms of employment, promotion or transfer by allowing such entities to give preference to persons of the same religion.

It is important these provisions do not have a negative impact on the medical workforce and patients' access to health care as a doctor may be:

- refused employment, promotion or career development opportunities because they do not adhere to the same religion affiliated with the hospital or aged care facility; or
- terminated because they act on their clinical/vocational responsibility to provide a health service to a patient that is inconsistent with the religious beliefs of the hospital or aged care facility (i.e. an inherent requirement of the position).

These provisions may limit the education, training and career development opportunities for many doctors should they be discriminated against by religious hospitals and aged care facilities for not adhering to a particular faith. This may cause distress to those already employed at such facilities who may fear dismissal based on their faith (or lack thereof) rather than their abilities.

In addition, many doctors may choose not to seek employment at all in these hospitals or facilities due to fears of being overlooked for employment in the first place, fears of being dismissed in the future and/or fears of not being given opportunities for career development.

Any negative impacts on the medical workforce could then limit patients' access to health care, particularly in rural areas, should these provisions result in limiting the number of doctors seeking, or actually selected, to work at a particular hospital or facility. Not only can these provisions potentially affect the number of doctors working at a particular hospital or facility but the diversity of doctors as well, particularly in terms of gender, qualifications and experience as well as cultural and linguistic backgrounds.

In relation to subclauses 32(8-12), it is recommended that:

- religious hospitals and aged care facilities are removed from this section; or,
- if including religious hospitals and aged care facilities, the section is appropriately revised in consultation with the medical profession to ensure they

do not lead to a negative impact on the education, training and career development opportunities for doctors as well as limit patients' access to health care, particularly in rural areas.

SUMMARY OF RECOMMENDATIONS

Religious discrimination legislation must reflect and uphold, and not undermine or override, professional standards. The AMA finds that sections of the *Second Exposure Draft of the Religious Discrimination Bill 2019*, as written, do not reflect and support the professional standards of the medical profession, rather the Bill appears to override those standards, reduce patient safeguards and derogate patients' rights to access health care.

In relation to the *Second Exposure Draft of the Religious Discrimination Bill 2019*, we make the following recommendations:

- Extend the timeframe for providing submissions on the Bill to allow individuals and organisations sufficient time to consult with their members and others (as relevant);
- Ensure religious discrimination legislation complements, and does not undermine or override, existing anti-discrimination legislation;
- Clarify the interaction between the Bill and professional standards as set by regulatory authorities such as AHPRA and the Medical Board;
- In relation to subclauses 8(6) and 8(7), either:
    - remove them from the Bill altogether to allow the medical profession to continue to be guided by professional standards set out by the Medical Board and other relevant regulatory authorities; or,
    - if maintaining a section on conscientious objection by doctors, revise the section in consultation with the medical profession to ensure they reflect, and do not undermine, professional standards.
- In relation to subclauses 32(8-12), either:
    - remove religious hospitals and aged care facilities from this section; or,
    - if including religious hospitals and aged care facilities, revise this section in consultation with the medical profession to ensure they do not inadvertently lead to a negative impact on the education, training and career development opportunities for doctors as well as limit patients' access to health care, particularly in rural areas.
- Should this Bill be enacted, doctors, other health care practitioners and the wider community must be appropriately informed as to how religious discrimination legislation interacts with current anti-discrimination legislation and how it potentially affects the provision of health care.