Religious Discrimination Bill – Exposure Draft

Your Submission

The Australian Women’s Health Network (AWHN) sought an extension of time for consultation on this important Bill. We regret that this extension was not provided given the ramifications of this Bill in a range of ways that have not been explored in public discussion.

We give particular attention to the proposed legislation’s impact on women’s health in section 8 (5) and (6).

There is no commentary available as to the problem that section 8 (5) and (6) is seeking to rectify. The lack of materials that are readily understood by a range of community members make informed comment and capacity to engage fully a problem in this important debate about the rights and freedoms of all Australians.

The Bill Explanatory Notes state in Clause 29 ‘In addition, the Bill provides that conditions, requirements or practices imposed on health practitioners which would have the effect of restricting or preventing a health practitioner from conscientiously objecting to providing a health service on the basis of their religious belief or activity are not reasonable in certain circumstances for the purposes of the test of indirect discrimination, and therefore will constitute unlawful discrimination’.

A lay person’s reading of section 8 (5) and (6) is as follows:

- It provides health practitioners with the right to refuse treatment to people and/or be involved in medical issues that conflict with the health practitioner’s religious beliefs.
- The clauses may only apply in states that already have conscientious objection provisions, or, the clauses could be read to apply in those that don’t, or, the clauses could be read to apply everywhere.
- It appears to over-ride other anti-discrimination legislation. It seems to propose that a person’s right to express their religious views over-rides the right of women not to be discriminated against on the basis of gender, pregnancy, sexuality, disability, relationship status etc.
- It appears to over-ride existing health professional conscientious object legislation and policy. It lacks clarity on the requirement for responsible behaviour of a health professional in ‘refusing to provide, or participate in, a treatment or procedure based on a conscientious objection because it directly affects patients’. Health professionals already have an ‘ethical obligation to minimise disruption to patient care and must never use a conscientious objection to intentionally impede patients’ access to care’. They are also required to ‘refrain from expressing their own personal beliefs to the patient in a way that may cause them distress’. This would include proselytising.

AWHN submits that the proposed legislation is confusing as to its operation and impact on the already existing significant body of State/Territory, health professional association and regulatory bodies and health service conscientious objection laws and policy and health service accreditation requirements on patient’s rights. (See Background)
AWHN submits that the confusion it will create potentially significant impacts on services which are sought and used by women seeking information and services for pregnancy terminations and contraception. This is particularly the case, for example with some health practitioners of Catholic and Muslim faith who hold particular views about women’s reproductive rights. The health practitioner’s rights to religious freedom seem to be privileged over the rights of women to make informed decisions about their own reproductive health and choices.

In the event that conscientious objection is permitted by law, the interests of the patient should always be put over those of the health practitioner, regardless of the practitioners beliefs. Any conscientious objection which is permitted should therefore always be specific to particular circumstances (as is the case for abortion and Voluntary Assisted Dying in Victoria) and there must be specific mechanisms to protect patient interests.

In practice, except in the most extreme circumstances, conscientious objections for health practitioners are generally not permitted, regardless of the practitioners beliefs. There is therefore a very real danger that a general right to conscientious objection on religious grounds will lead to a significant expansion of discrimination and harm to patients.

AWHN submits that there is no need for the inclusion of section 8 (5) and (6) as the right to health professional conscientious objection is already in operation across Australia in current clinical practice, and in some States in legislation. It should be removed from the Bill. If this is not to be the case, it should be a second trach of possible inclusions and referred to the Australian Law Reform Commission for its view, or at a minimum to a parliamentary committee for extensive enquiry.

Background
Section 8 (5) and (6) extract
‘Conditions that are not reasonable relating to conscientious objections by health practitioners
(5) For the purposes of paragraph (1)(c), if a law of a State or Territory allows a health practitioner to conscientiously object to providing a 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.
Note: A requirement to comply with a health practitioner conduct rule that is not reasonable under this subsection is also not an inherent requirement of work (see subsection 31(7)).
(6) For the purposes of paragraph (1) (c), if subsection (5) 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.
Note: A requirement to comply with a health practitioner conduct rule that is not reasonable under this subsection is also not an inherent requirement of work (see subsection 31(7)).’

The proposed definition of health practitioner is broad
• health practitioner means a person who, under a law of a State or Territory, is registered or licensed to provide a health service.
• health practitioner conduct rule means a condition, requirement or practice:
  (a) that is imposed, or proposed to be imposed, by a person on a health practitioner; and
  (b) that relates to the provision of a health service by the health practitioner; and
  (c) that would have the effect of restricting or preventing the health practitioner from conscientiously objecting to providing the health service because of a religious belief or activity held or engaged in by the health practitioner, being a religious belief or activity that may reasonably be regarded as being in accordance with the doctrines, tenets, beliefs or teachings of the health practitioner’s religion.

• health service means a service provided in the practice of any of the following health professions:
  (a) Aboriginal and Torres Strait Islander health practice;
  (b) dental (not including the professions of dental therapist, dental hygienist, dental prosthetist or oral health therapist); 1
  (c) medical
(d) medical radiation practice;
(e) midwifery;
(f) nursing;
(g) occupational therapy;
(h) optometry;
(i) pharmacy;
(j) physiotherapy;
(k) podiatry;
(l) psychology.

There are already longstanding health professional practice arrangements in place. For example:

AMA Position Statement Conscientious Objection 2019 extract.
1. Preamble
1.5 A doctor’s refusal to provide, or participate in, a treatment or procedure based on a conscientious objection directly affects patients. Doctors have an ethical obligation to minimise disruption to patient care and must never use a conscientious objection to intentionally impede patients’ access to care.

2. Patient Care
2.3 A doctor with a conscientious objection should:
- 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.

ANMF Conscientious objection policy
It is the policy of the Australian Nursing and Midwifery Federation that:
1. Nurses, midwives and assistants in nursing (however titled) have a right to refuse to participate in procedures which they judge, on strongly held religious, moral and ethical beliefs, to be unacceptable (conscientious objection)1. Fear, personal convenience or preference, are not sufficient basis for conscientious objection.
2. In exercising their conscientious objection, nurses, midwives and assistants in nursing must take all reasonable steps to ensure that the persons preference, quality of care, safety, and advance care directives are not compromised.
3. Subject to their scope of practice, nurses and midwives in the course of their employment, must not refuse to carry out urgent life-saving measures or procedures.

Pharmacy Guild Australia
Code of Ethics for Pharmacists 2017 extract
CARE PRINCIPLE 1
A pharmacist makes the health and wellbeing of the patient* their first priority.
The care, wellbeing and safety of the patient should be at the centre of all pharmacy practice. This principle applies to all pharmacists, even when not providing direct care to a patient.
A pharmacist:
a. fulfils their duty of care to the patient first and foremost.
b. works to ensure their duty of care is not compromised by other interests and manages potential conflicts in the interests of the patient.
c. provides care in a compassionate, professional, timely, and culturally safe and responsive manner.
CARE PRINCIPLE 2

A pharmacist:

a. respects the dignity and autonomy of the patient.

b. recognises and respects patients’ diversity, cultural knowledge and skills, gender, beliefs, values, characteristics and lived experience, and does not discriminate* on any grounds.

c. encourages patients to participate in shared decision-making*, and assists by providing information and advice relevant to the patient’s clinical needs in culturally appropriate language, detail and format.

d. explains the options available, including the risks and benefits, by providing information that is impartial, relevant, up-to-date and independent of any personal commercial considerations to help patients make informed decisions.

e. consults with an appropriate carer or substitute decision maker* if the patient lacks the capacity to provide consent.

f. respects the patient’s choice, including the right to refuse treatment, care or advice, or to withdraw consent at any time.

g. ensures compliance with the patient’s legal right to privacy and confidentiality as outlined in the Australian Privacy Principles* with appropriate security and safeguards applied to digital and hard copy information.

h. informs the patient when exercising the right to decline provision of certain forms of health care based on the individual pharmacist’s conscientious objection*, and in such circumstances, appropriately facilitates continuity of care for the patient.

Australian Commission on Safety and Quality in Health Care

All Australian health services are required to be accredited under the National Safety and Quality Health Service (NSQHS) Standards. These standards require health service organisations to use a charter of rights that is consistent with the Australian Charter of Healthcare Rights. This means that health services may adopt the Charter, or develop their own charter.

Australian Charter of Healthcare Rights (second edition) 2019 extract

I have a right to:

Access - healthcare services and treatment that meets my needs.

Safety – receive safe and high quality health care that meets national standards; be cared for in an environment that is safe and makes me feel safe.

Respect – be treated as an individual, and with dignity and respect; have my culture, identity, beliefs and choices recognised and respected.