MEDICINES, POISONS AND THERAPEUTIC GOODS BILL 2013

Consideration in Detail

Resumed from an earlier stage of the sitting.

Clause 97: Practitioner to inform CEO of drug dependent status of patient —

Debate was interrupted after the clause had been partly considered.

Dr G.G. JACOBS: I say to the minister that I do not intend to protract this process too much.

Dr K.D. Hames: Mr Speaker, I second that motion!

Dr G.G. JACOBS: But I do believe that we need to —

Several members interjected.

Dr G.G. JACOBS: I do!

Several members interjected.

The SPEAKER: Members!

Dr G.G. JACOBS: I refer the minister to clause 97(2), where it refers to a practitioner who reasonably believes that a person is suffering from a drug addiction, who then needs to make a report to the CEO within 48 hours. I succinctly ask: when does the clock start ticking for the 48 hours?

The SPEAKER: Minister, when does the clock start ticking?

Dr K.D. HAMES: From the time when the doctor forms a reasonable belief.

Dr G.G. JACOBS: This is just my point, how can we know when the practitioner has a reasonable belief?

Dr K.D. HAMES: It is up to the doctor to determine when he or she forms a reasonable belief. Given the issue that no people have yet been prosecuted, but if they were, it is then the responsibility of the prosecuting team to prove that the doctor had a reasonable belief for 48 hours. The prosecution then need to work out when that reasonable belief was formed. The member for Eyre provided an excellent example when talking about the naltrexone clinic. When would a doctor working at that clinic form a reasonable belief that his patient is an addict? One would assume that when the doctor books his patient in for an implant it is at that stage that he has reached a reasonable belief. For a practitioner working at that clinic, it would be easy to prove. But for the member for Eyre, it would be harder to prove. He might mull on it for 24 hours and not form a reasonable belief. However, if the matter reached a stage where the health department had to produce evidence to show that the member had formed a reasonable belief, it would have to do so. It may well be that it is the member's own notes that might say the date as to when he noted his patient is a drug addict.

Again, given that a prosecution has not occurred makes it difficult. But people should remember that this provision has been in the act. The time period, as we have said, is not unreasonable. Clearly, the member for Eyre does not agree, but that is the position we are taking. There is not sufficient reason to change the legislation from what it is at present. There is no compelling evidence to suggest that the current act is wrong in any way because there have been no complaints against it and no action taken on it.

Mr M.P. MURRAY: Having heard many questions about the bill, I am very interested in its background. I ask whether the minister had any consultation with the Australian Parliamentary Group for Drug Law Reform and the Australian Drug Law Reform Foundation, who are quite active in this area. Their views are quite different from what the minister is putting forward. I refer to the Australian Drug Law Reform Foundation's charter that sets out a series of principles. It states —

> … to encourage a more rational, tolerant and humanitarian approach to the problems created by drugs and drug use in Australia.

When the minister was formulating this legislation, did he speak to these stakeholders?

Dr K.D. HAMES: To the best of my knowledge, we have not had any consultation with them. I have to say that I have not heard of them. But I repeat the point that I made before; namely, that this legislation has been out since 2012. They had ample opportunity to make submissions around this legislation. In fact, prior to this legislation, they had ample opportunity to make representations about the previous legislation, which contains clauses that have great similarity. Certainly, the 48-hour component is the same clause. These groups have never made a representation to me to suggest that the clause is inappropriate.

Mr M.P. MURRAY: Further to that point, I find it surprising that the minister is walking away from a parliamentary group that represents the other states in Australia without seeking its thoughts and views. It is very much biased towards the federal arena, but anyone can join that group. Certainly, it seems that its views are quite

different from the minister's, but the issue still comes back to the register. We have heard varying views from different people and it is probably the same person, including me, having varying views.

The SPEAKER: Member for Collie–Preston, the Hansard reporter cannot hear you. So can you speak loudly and clearly? Thank you.

Mr M.P. MURRAY: I will try my best, Mr Speaker. Most times in here you tell me to shut up! I will lift the tone just a little.

There are varying views on this part of the legislation about the register for people who are deemed to be, or not deemed to be, drug addicts. I certainly have some concerns about the word "addict" and the way that is used here. Although we talk about it mainly in medical terms in this case, if the minister is coming through with legislation such as this, why is there no further legislation to cover addicts in other areas? We have spoken previously about many of those other areas, such as alcohol. Does the legislation also pick up those people?

Mr R.H. COOK: I am not quite sure why the member did not get a response from the minister then.

Dr K.D. Hames: You answered him yourself; I saw you.

Mr R.H. COOK: That was just an opinion. The minister has never been happy with my opinion before so this is a good opportunity. I want to come back to the issue of reasonable belief. Before the break, we discussed that there are established precedents in prosecutions in other states. I wonder whether the minister could provide a definition of "reasonable belief" for the purposes in this part of the legislation.

Dr K.D. HAMES: I think I did that before. Is there a definition of "reasonable belief"? No, I did not do it before. Before I referred to what the court said. Here it is—reasonable belief. *Macquarie Dictionary* defines "reasonable" as —

> not exceeding the limit prescribed by reason; not excessive: *reasonable terms*.

It defines "belief" as —

> conviction of the truth or reality of a thing, based upon grounds insufficient to afford positive knowledge …

That is a beauty. There is a number of cases in which reasonable belief has been considered by the courts. I gave this example before and *Hansard* will have it already; in Reeve v Aqualast, the Federal Court of Australia stated that for the test of reasonable belief —

> … there must be some tangible support that takes the existence of the alleged right beyond mere "belief" or "assertion" by the applicant.

Mr R.H. COOK: That clears that up! I am not quite sure where that leaves us.

Dr K.D. Hames: The lawyer, the member for Armadale, will help us out, I think.

Mr R.H. COOK: We may come to rely upon him. Belief is almost a question of faith. It comes down to a very subjective point of view, does it not? The role of the prosecutor must be to ascertain that, even though only two people were in the room at the time, it would be reasonable for the doctor to have formed that view, and the other is that the doctor had to have formed that view but acted contrary to it. From that point of view, I share the member for Eyre's concerns about the point at which a court or anyone forms the view that a doctor has been unreasonable.

Dr K.D. Hames: I think the member for Armadale will answer the question for me.

Dr A.D. BUTI: Any time that "reasonable" is used in legislation that is before the courts, it is an objective measure. It is important that this is cleared up because the judges will go to *Hansard* for the intention of the legislation. If we have "reasonable" in the legislation, that is generally the objective bystander. In other words, when a doctor makes a decision, would the person judging that see that as reasonable? It is not a subjective assessment. It is the objective standard. It is really important for us to clear that up.

Dr K.D. HAMES: The member for Armadale is right. I concur. I remember now that the member mentions it, we have done that with other legislation in the past and we have talked about that. We talked about it previously when discussing legislation on home invasions and the reasonable belief that somebody invading somebody's home had intent to harm. We discussed changing the legislation to give people more power to defend themselves in the home. The question was whether the average person looking in would think that the actions taken by the person inside the home to defend themselves were the right thing to do. I have used that explanation with constituents who have complained one way or the other. If someone shoots a young 16-year-old kid coming into their house and they say, "I believed that he was going to assault me and so, quite rightly, I shot him", would the average person in the street think that was a reasonable belief? No, they would not. If the guy came in wearing a

balaclava with a knife in his hand, the average person may well think that the person who defended themselves held a reasonable belief that they were going to be assaulted. I accept the definition that the member has given.

Mr M.P. MURRAY: I am very concerned about the minister's offhanded treatment of my previous question. I think the minister's arrogance is starting to come through. Those who practise in the industry seem to know all that is in the industry, and that is certainly not the case when we talk to parents, service providers and those sorts of people. I again bring us back to the issue of the addict register, which to me will stop people from seeking help. That is my main concern. Under this legislation, is there any other way that people can seek help without seeing what the minister would probably term a "dodgy doctor" who will not put them on the register? Under this legislation, how can people seek help without being put on the register?

Dr K.D. HAMES: That person can seek help from a doctor without needing to be put on the register. They cannot source drugs as part of that unless in doing that they confess —

Mr M.P. Murray: I consider, in both ways, help and needing a drug could be the same.

Dr K.D. HAMES: It may be difficult if they confess that they are a drug addict, as the doctor would have responsibility. If I did not answer the member's question, it is not because I did not understand the member's point. It is just that, firstly, the member asked about dealing with other addictions and the member for Kwinana made the point that this legislation does not cover addictions to alcohol. Secondly, I understand the point that the member made; he believes that it will keep people from seeing a doctor. I just do not agree with the member, so there is no point in me continuing to stand and answer to a point that the member made. He has made the point; it is on the record in *Hansard*, it is just that I do not agree.

Mr M.P. Murray: I have changed because I have heard that. I am asking where those people can go without being in this system.

Dr K.D. HAMES: To seek assistance? It depends what they want to do. They can go to any specialist and not necessarily confess that they have an addiction to hard drugs; they could just say that they have health issues and want assistance. They may want to see a psychiatrist and have help with their issues. There are also counselling services for people with drug and alcohol addictions. People can go to lots of different support groups and non-government organisations that provide assistance to people who have drug addictions. They are the main source of help. If they go to a doctor, they will be obliged to put them on the register. I just need to clarify something if I may. Only people who have the authority to prescribe medication need to report to the CEO. A person can go to a psychologist, for example, who cannot prescribe any drugs of addiction, and confess all they like. That is probably one of the best avenues of treatment. As a doctor, I do not think we are that crash-hot at treating people with addictions. We can provide moral support and sit down with patients and talk them through issues, but a lot of other allied health professions, community groups and not-for-profit organisations can provide a lot more intense moral support, backup and experience because a lot of them have been addicted to drugs themselves and are involved in non-government organisations to assist people to get off drugs. I think they are the more appropriate people to go to. The main reason they go to a doctor is to get more drugs, not because they want counselling or assistance to get off them.

Mr R.H. COOK: The member for Armadale intervened in today's discussion and his comments were very illuminating. I think I have a better understanding of why the term "reasonably believes" could be used in the context of this sort of legislation. I will now move the amendment in my name simply to stimulate a discussion that will enable me to finally nail the issue of the prosecution of a doctor. I move —

Page 65, line 18 — To delete "reasonably believes" and substitute —

reaches a diagnosis

I think the member for Eyre has been heading down this path much more effectively than I must say I have. The opposition is trying to work out at what point a health professional will decide that someone has a drug dependency. We have discussed the definition of drug dependency and we have agreed to disagree with the government on it. We moved an amendment that was defeated. I was saying that the wording "reasonable belief" is in ambiguous territory and questioning whether it is reasonable for the health professional to conclude that the person in front of them is a drug addict or, to be technical, a drug-dependent person. I am endeavouring, therefore, to define in some way a more objective analysis, or a more helpful process towards an objective, scientific approach, that will enable us to rely upon a process of discovery and conclusion in a clinical environment with which there is universal agreement.

I am not a doctor, but I understand that a diagnosis involves a very clear process of observation, of undertaking tests and of coming to a conclusion based upon the evidence before the doctor. It is done in a very accepted framework and a conclusion comes at the end of it. It is a very well understood, documented pathway that doctors take to reach a conclusion. With this amendment I am proposing a better way to go about it because we

can assess that diagnosis in a scientific way and, therefore, come to a very clear-cut conclusion about whether integrity was attached to the diagnosis—and, if so, what is the outcome? If no integrity was attached to the diagnosis and it fundamentally fell short of what is considered good, clear-cut practice in the way it is widely understood within the medical field, the CEO would be in a position to prosecute. As the minister has pointed out on many occasions in this debate, the purpose of this bill is to prosecute doctors who continue to administer and prescribe drugs unnecessarily.

Dr G.G. JACOBS: I think the whole tenor of our discussion has been that "reasonably believes" has a fair bit of, if you like, fluffiness around it. We have asked what parameters we should use for a reasonable person to say that, based on the evidence, a doctor should have believed that a person was addicted. I can understand where the member for Kwinana is coming from regarding "reaching a diagnosis", but if a doctor does not reach a diagnosis, even though the evidence shows that they should have, it is open for a potential cohort of doctors to say that they have not reached a diagnosis. The question then is: what about the doctors who did not reach a diagnosis but blind Freddie could see from the evidence presented by the patient that they were addicted? Does the member for Kwinana understand what I mean?

Mr R.H. Cook: Yes.

Dr G.G. JACOBS: I do not know whether we can ever legislate this in a totally comprehensive way to nail it. It is almost impossible. The member is trying to provide for a person to reach a conclusion when that person is not in the doctor's room, does not know the facts and does not know the situation and is trying to put themselves between the patient and the doctor at that time. I understand, but I have been trying to get some more clarity around "reasonably believes". But as the member for Kwinana was talking, I was thinking that if we just use "reaches a diagnosis" a cohort of doctors could be presented with drug addict X, who obviously presented enough evidence for that cohort to reach a diagnosis of addiction, but they do not. Their cop-out to the CEO would be, "Hang on; I hadn't reached a diagnosis." I do not know what more I can say to make the point, but I understand the fluffiness of "reasonably believes". With "reached a diagnosis" the provision will be sort of overprescribed. A doctor can always say, "I was treating a patient and gave him drugs but I did not reach a diagnosis of addiction."

Dr K.D. HAMES: The member for Kwinana said that reaching a diagnosis is a clearly defined term, but it is not. When we, as doctors, even as medical students, finish our reports, we draw a little triangle on the page, which means "diagnosis". To give the member a clear idea, I will talk about an appendicitis. If I indicate that the diagnosis is an appendicitis, I will have certainly formed the view that the patient has an appendicitis. But if I put "diagnosis appendicitis" with a question mark, I still have a diagnosis but it is a possible appendicitis. I will not have decided and I might not know until I take out the appendix. Is a diagnosis a final conclusion? If I said my diagnosis was appendicitis, I would have said that because I had formed a reasonable belief that the patient had appendicitis. As we have heard from the member for Armadale, a "reasonable belief" is a recognised legal term, whereas "reaches a diagnosis" is not is a recognised legal term. We are talking about something that may proceed to court, and it will be a lot harder for the legal professional to understand what we mean by "reaches a diagnosis". The member for Eyre then talked about what a GP might do to dodge the whip on that issue. To say "reaches a diagnosis" is not adequate, and it is not an amendment we will agree to.

Mr M.P. MURRAY: These days we have stringent controls with drug testing at workplaces and even when someone applies for a job. If a person were tested three or four times and each time drugs showed up, would that lead to their being put on the register? Testing has moved on now and it is not just a pee in a bottle anymore. I do not understand what the test is, but I am sure the doctors in this chamber do.

Dr K.D. Hames: The answer I have been given is no, because that does not mean a person is dependent on that drug.

Mr M.P. MURRAY: Testing has gone even a step further and I have heard construction workers say that they have had a DNA test. I am not sure what that means, but it is probably a deeper analysis than just a urine sample. In fact, it is so comprehensive that a young bloke, who I thought looked very healthy, was diagnosed with kidney cancer and was rushed straight in for an operation after receiving the results of this so-called DNA test on the construction site. It is a strong test and is not just the usual water bottle test. Could this sort of test become part of the regime that could place someone on the register?

Dr K.D. HAMES: DNA is to do with a person's gene structure, so I do not know what test the member is talking about. I am not aware of any method in which a gene structure test has any relevance to the bill. I think the member might have his letters wrong, and it has another name.

Mr M.P. Murray: It is a slang term that is used on site.

Dr K.D. HAMES: I do not know the answer without knowing the test, but I am fairly certain it has nothing to do with the amendment that is before the chamber.

Mr M.P. MURRAY: If a person fails the test three or four times, and it is more comprehensive than just the waterworks test, a blood test or those sorts of things, at which point does the doctor say this person has a problem?

Dr K.D. HAMES: The member is talking about a urine drug test and then a blood drug test. They mostly test for cannabis and other drugs.

Dr G.G. Jacobs: Even if they test blood or urine, a positive result does not mean a person is addicted.

Dr K.D. HAMES: The member for Eyre is right. The answer is the same that I gave to the first part of the member for Collie–Preston's question.

Dr G.G. JACOBS: I do not want to protract this debate. I can see why the minister might think it is overprescribing, which is not a legal term. Can the minister tell me which parameters the reasonable man in the street would use in a case in which it is thought the doctor would have, if you like, come to the conclusion that a person was addicted? What parameters in the words "reasonably believes" will be used or are used?

Dr K.D. HAMES: The term "reasonable belief" in whatever form or forum it is used is determined through the court process, usually by precedent in other court action. I might give the member my views on what someone would think is reasonable, like George O'Neil with Naltrexone, but on a lesser scale for GPs. At the end of the day, those things are determined by the courts. They are normally based on the testimony of expert witnesses, such as another doctor. Another doctor might present a case and then the court forms a view. Until there is precedent from cases that go before the court, it is hard to determine what gets over the threshold that determines reasonable belief.

Dr G.G. JACOBS: May I suggest that medical records would be a very important part of that determination, because there would be comments in the record that would suggest, perhaps, there was some suspicion by the doctor that he might have an addict in front of him. Of course, as we talked about before, there is the issue of the repetitive request and nature of the request for drugs. That obviously would be part of forming that reasonable belief of addiction, I am sure.

Mr R.H. COOK: I want to conclude my remarks on the term "reaches a diagnosis". By way of this amendment, I was trying to provide clarity and structure around this part of the bill. I accept the member for Armadale when he says that a court would in all probability look at what would be the construction of a reasonable belief. I am not a lawyer like the member for Armadale, who has just had to leave the chamber, but the wording of subclause (1) is "an authorised health professional who reasonably believes"; it is not "who should have come to a reasonable belief". It is not an analysis or objective view about what this health professional believes; it strikes me this is very much a subjective view around what the health professional honestly believes and not what someone would normally expect that person to conclude from having this particular patient in front of them. As the minister knows, one of the opposition's concerns is around the extreme nature of the fines associated with transgressing this clause. Even though the clause is somewhat different from those in the current regulations, the minister assures us that no-one has ever been convicted under the current system and the current system will continue so no-one will be convicted under these regulations. I can see how he comes to that conclusion when I read the wording of the clause. Perhaps, we are all worried for nought as we have drafted a piece of useless legislation that will never see anyone convicted or fined $15 000, so the time we are spending agonising over the words will amount to nothing. I am happy, member for Eyre, to have any words other than "reasonably believes". Earlier the member for Eyre mentioned what I hope is a legal phrase and referred to blind Freddy. Perhaps blind Freddy needs to be brought into the legislation to provide more clarity. By moving this amendment, perhaps in an ill-informed way, I thought there was some sort of science around the clinical process that would provide us with an objective way to judge the conclusions that the health professional comes to. If that is not the case, I will let members judge the amendment as they see fit.

Amendment put and negatived.

Dr G.G. JACOBS: I want to talk about the consequences for a medical practitioner who is found to have breached this legislation and is prosecuted for not being of reasonable belief and then reporting within 48 hours that he has a drug addict in front of him. What impact would a conviction have on that medical practitioner, and would it jeopardise that practitioner's medical registration?

Dr K.D. HAMES: That does not come under this legislation. The consequences of these things will be an issue for the medical registration board to determine. But doctors have been fined in the past. Many things may cause people to come before the medical registration board, and a fine would be one of them. As the member would know, some doctors are now restricted from prescribing those types of medications as a consequence of probably

misbehaviour on their part in prescribing drugs or using drugs. I spoke earlier about a doctor whom I used to work with who was misusing anabolic steroids. That doctor was still given by the medical board a licence to practise, but with restrictions—restrictions that I might say at the time he was not adhering to, but I did not know that he was on restrictions, or perhaps the restrictions had been applied after he had been caught.

The member needs to remember that I will be moving to amend the fine to a maximum of $5 000 rather than $15 000. It is my personal view that the medical board would take that into account. The medical practitioner would not be fined unless he had been prosecuted; and, if he had been prosecuted, the board would know. As the member would also know, when a person renews his registration, he has to state whether anything has occurred since his last registration, such as a conviction.

Dr G.G. Jacobs: That is why I asked the question.

Dr K.D. HAMES: This question really is not one that I can answer. Only the medical board could answer whether it would take into consideration a fine for this offence. My personal view is that it would not. The member for Kwinana has made comments about the lack of aggression in this legislation. The department spends a lot of time working with doctors to try to better manage people's behaviour. As we have said, Dr O'Neil, and others, have led us to doctors who are not behaving in the right way. At the end of the day, the fine stands as the final punishment for the recalcitrant doctor who will not listen and will not change his behaviour and keeps giving people lots of drugs. That is the final step that we reach—and no doctor has reached that step yet, because most of us value our profession and our integrity and want to continue with our practice.

Dr G.G. JACOBS: The reason I ask the question is that the original fine in this legislation was a maximum of $15 000. That indicates to me that the original intent was this would be seen as a fairly serious misdemeanour. If this is seen as a serious misdemeanour, I am just wondering whether the minister's knowledge in this area would suggest that that would impact on a doctor's medical registration, and also on his indemnity, because the same questions are asked for that as well. Perhaps the minister could provide that as supplementary information.

Dr K.D. HAMES: I do not know how I would be able to get that information, because at the end of the day it is a decision by the medical indemnity board or the medical registration board. The fine of $15 000 was not with the intent of escalating the recognition of this as being much more severe. It is just the way these things are done in legislation. This fine of $15 000 is just to match the minimum fine that was previously in the regulations but will now be in the legislation.

Dr G.G. Jacobs: Do you mean as per inflation?

Dr K.D. HAMES: It is more than inflation. Previously it was outside the legislation and in the regulations; now it is inside the legislation. Most of those legislative punishments are of a much greater amount. Remember, that is not the amount the person will be fined. It is the maximum that the magistrate can fine the person. The magistrate can fine the person $50 if that is what he wants to do. It will be up to the magistrate to determine the severity of the offence and provide the appropriate financial penalty. We would probably get to the maximum fine of $15 000 only if a doctor had repeatedly continued to prescribe drugs to a person, despite discussions and warnings, and despite knowing that the patient was a drug addict, and had put his finger up to everybody and said, "I don't care; I'm going to keep prescribing morphine to whoever walks in the door and asks for it." I think it would be extremely unlikely that we would get to that situation with any GP, frankly.

Mr R.H. COOK: We have dealt with subclause (1) and we are making some progress, I am very pleased to say, Mr Acting Speaker.

The ACTING SPEAKER (Mr P. Abetz): We are inching forward, yes.

Mr R.H. COOK: Storming forward.

The minister has put out a couple of confused and different scenarios in relation to what this legislation is about. The first—this is the image that I take forward—is that doctors are doing the right thing and want to protect and promote their profession and care for their patients. But there are also the overprescribing and reckless doctors who have little regard for the care of their patients.

My concern about this legislation is that it will require a doctor to pass on information to the CEO, and the CEO can then do a number of things with that information. Essentially, the CEO can do a range of other things if the CEO believes that is in the best interests of the drug-dependent person's health and welfare. I have placed on the notice paper a further amendment to clause 97. I showed this amendment to the minister earlier, and the minister was happy to provide me with his opinion on this amendment; therefore, I am sure it will meet with defeat. However, I will move the amendment regardless. I move —

Page 65, after line 22 — To insert —

> (1A) It is a defence to a charge under subsection (1) to prove that the authorised health professional considered it to be in the best interests of the patient's health to not make a report in accordance with subsection (2).

The reason for this amendment is the scenario that the minister spoke about earlier when he talked about his personal experience. We have talked about the hypothetical case in which a person goes to his doctor and says, "I have a bad back. I now have to take more of these drugs to relieve the symptoms of that bad back, and in fact I now look forward to taking these drugs and I think it is becoming a problem." I think we are all of the view that it would be unreasonable to compel that doctor to then provide that person's name to the CEO so that it can be placed on the register, because, frankly, this person is developing a drug dependency as a result of the care being given by that doctor. This person is not what we would call an addict and is not recklessly misusing drugs, but is still in the care of a single doctor who prescribes drugs for a specific condition and who best manages their dependency. We want to see that patient cared for; we want to see them resolve their issues with their developing drug dependency and their bad back. The last thing we want to see is that patient added to a list to which their name will forever be attached—unless they are one of the very lucky 70 so far who have got off the list since it has been in operation. Secondly, we want that patient to resolve their issues. The doctor might be of the view that he can do one of two things: he can put this person on the list and then no longer assist them with their bad back or he can continue to care for the person and get them off the drugs. The doctor does not want this person go onto a methadone program; he wants the person to receive care for their bad back, but for that to be done carefully so that their developing drug dependency is also managed. I think that is a much better way to proceed, because we are protecting that person's health and welfare rather than jettisoning them onto this central register.

Dr K.D. HAMES: This is about protecting the patient and that is why we cannot accept this amendment. There is nothing wrong with the doctor seeing that patient and the doctor continuing with the care of that patient. If the doctor does not believe that the patient is addicted to the drugs, he will not have to put them on the register. If he believes that the patient has become addicted, the doctor does have to put them on register, but that does not change the relationship between the doctor and the patient. It stops that patient going to another doctor, when otherwise that doctor would have no control over who that patient goes to see. Therefore, being put on the register protects the patient. If they have started on drugs that may lead to addiction, being put on the register prevents them starting the process of shopping around for drugs from other doctors. Even if the doctor formed the belief that that patient may be addicted to the drugs being prescribed and reported that to the authority, he could get authority to prescribe those drugs to the patient, even in increased doses, if medically required. That doctor becomes the authorised doctor looking after that patient and giving those medications. When the doctor has to provide the name that goes on the register, it can come off in a process that has become easier in the longer term, which we will get to in clause 107. Still, it is very important to prevent that patient from doctor shopping by having them recorded on the register, and no-one else will ever know that they are on it unless that patient starts shopping around to other doctors.

Dr G.G. JACOBS: I do not want to differ from the member for Kwinana, but my reading is that the next clause, clause 98, follows on from the report. It states that the CEO may decide to include the name of a person. Before making a decision, there is a certain process, and this is made particularly evident in clause 98(2)(b), which states —

> give the person a reasonable opportunity to show why his or her name should not be included on the drugs of addiction record.

I think there is a bit of patient protection in clause 98. Correct me if I am wrong, minister, after the doctor makes a report, the CEO considers it as per the process in clause 98.

Dr K.D. Hames: That does not need an answer, does it? The member has described what is in clause 98 and he is correct.

Mr R.H. COOK: This may be jumping the gun a bit, but clause 100 describes the prohibition of prescribing to a person whose name appears on the drugs of addiction record. Perhaps, by way of explanation, the minister might talk about the regulations he envisages in relation to this clause. Is it true that a doctor, once he has put the person on the drugs of addiction record —

Dr K.D. Hames: Can we not do this when we get to clause 100?

Mr R.H. COOK: We can, but —

Dr G.G. Jacobs: When the doctor reports to the CEO, he goes through a process to put that person on the record, and the process is outlined in clause 98.

Mr R.H. COOK: That is right, but the point I am trying to clarify —

Dr G.G. Jacobs: Just because a doctor reports the patient, it does not automatically put the patient on the list—it may do, but there is a process.

Mr R.H. COOK: I understand that, but the point I am trying to pick up on is the minister's comment that there is nothing to stop that doctor not caring for that patient. It might be the prescription of other schedule 4 or schedule 8 drugs—I do not know—but that may be what the doctor thinks is reasonable to assist this person with, first, their bad back and, second, their developing dependency. Under clause 100, that cannot be done, but clause 100 also describes regulations under which it can be done. Unless regulations allow for that to be continued, which is what the minister is envisaging, we will find ourselves in that situation.

Amendment put and negatived.

Mr R.H. COOK: Earlier in his remarks, the minister referred to the form appended as a schedule to the Drugs of Addiction Notification Regulations 1980. Could the minister clarify what information he envisages the practitioner will provide, other than setting out the grounds on which the doctor's belief is reasonable? We all have a very good understanding of what reasonable means—not. While we are at it, so we can expedite the process, what on earth does a person's occupation have to do with the assessment of whether they should be on the record?

Dr K.D. HAMES: There will be a new form that I believe will be simpler. The member raises a good point. I have been advised that a person will not need to list their occupation on the form, because, as the member says, there is no good reason to do so.

Clause put and passed.

Clause 98: CEO may include drug dependent person on drugs of addiction record —

Dr G.G. JACOBS: Regarding this clause about including a drug-dependent person on the record, clause 98(2) states —

> Before making a decision … to include the name of a person on the drugs of addiction record the CEO must —
>
> (a) inform the person of —

A list of things then follows. How is a person informed? Are they informed by phone, letter, fax or email? What if they migrate somewhere else?

Dr K.D. HAMES: I previously discussed this with the Acting Speaker, who was concerned, and quite rightly so, about some addicts, perhaps a young addict who is seeking treatment but still living with their family, and the family is not aware of this. I must admit I would like the family to be aware, and I think that it is in the best interests of the child for the family to be aware, but there are issues of confidentiality.

Dr G.G. Jacobs: It might not be a child. It might be a 30-year-old person living with their parents.

Dr K.D. HAMES: That is right. We will prescribe that through regulation and address the issues raised by the current Acting Speaker. We are still formulating the specifics of how we will confirm someone's identity and address so that we do not go to a house that turns out to be the wrong house or send a letter to a person who is not living there anymore. Identification will be done first. We suggested an opt-out clause whereby when a doctor notifies the chief executive officer, the patient is given the opportunity to say that they do not want their letter to go to a home address but through the doctor. The doctor gets the confirmation of the list, but, perhaps, the response for the patient could be sent via the doctor or to an alternative address as specified by the patient. That is something we will work on, and it will be decided through regulation. Our aim is to protect the identity of the patient but still allow them the opportunity to say, "No; that is rubbish. I am not an addict. Show me the proof that I am. Maybe I said that I was in conversation, but really I am not." The critical issue is to give the person who is being added to the list the opportunity to know that they are being added to the list, and to know that in a confidential manner.

Mr M.P. MURRAY: I spoke a couple of clauses back about the concerns that I have; if a letter is sent to the family home of a person who is aged over 18 years—I know the minister said a person can choose, but sometimes they do not do that—and is opened by the person's sister, in a small town that would very quickly get around. I see the problem to be one of confidentiality. I just know that with the nature of some of these people, the mail that comes —

Dr K.D. Hames: Can I just say this to help out? The letter will not go to a person saying, "You have been put on a register because you are a drug addict." The letter will say, "Can you please contact the Department of Health." It will not have any details of the specifics of their medical problem; it will just say to contact the Department of Health.

Mr M.P. Murray: Thank you.

Clause put and passed.

Clause 99: Recording and notification of drug dependent status —

Mr R.H. COOK: Minister, I have two questions on clause 99. The first is about informing the CEO. Under this part of the legislation the CEO is authorised to inform other people who is on the register, which includes the health profession that dobbed the patient in —

Dr K.D. Hames: Dobbed?

Mr R.H. COOK: That is essentially what has happened.

The CEO would also inform other persons, including the primary healthcare provider. Could the minister please clarify, perhaps by way of example, how that process would take place?

Dr K.D. HAMES: I am advised that it would be established who the regular medical provider is, and that may well be through the patient. The regular medical manager of that patient would be the one notified. That is my answer.

Mr M.P. MURRAY: It might be a little bit late in the day, but I am starting to become confused, as we seem to be going back to the core of the issue—a person's anonymity. There are now many areas in which leakages could occur—with toing and froing between different people as we go through the bill. At first it was only the CEO, and now we have the primary healthcare provider. I am not sure how information is relayed back—by letter or personal email—to the primary health carer. The primary health carer may have a personal assistant who opens their mail and reads it. I am still very concerned about the privacy of the person who may be on that register.

Dr K.D. HAMES: I am not sure what the member's concern is exactly, but I think it is this. Suppose there is a woman in Collie with a regular family doctor who she sees all the time. She has developed a drug dependency and does not want to go to that doctor because he is a good friend of the family and president of the local footy team. She goes to a doctor in Bunbury and confesses to being an addict, and the Department of Health contacts the regular doctor and tells him that she is on the list. Is that the member's concern?

Mr M.P. Murray: Leakage.

Dr K.D. HAMES: The issue is that he is not allowed to blab.

Mr M.P. Murray: The more it is handled, the more it is open to abuse and there is the chance of leakage.

Dr K.D. HAMES: There are only two people involved; there is nobody else. The only people involved are the doctor who reported her, saying he believes that she is an addict, and the patient's regular doctor if the Department of Health has established that there is a regular doctor. I am not yet certain how that would be done. It could be done only by asking the patient, so the Department of Health has no way of knowing who the regular doctor is. When the Department of Health notifies the patient that they are on the list, and asks whether the patient has a regular doctor to whom they want to give that information, they have only to say they do not have a regular doctor and have seen only the doctor who made the notification. Alternatively, the person could say that their doctor is "such and such in Collie and I would like him to know". That doctor specifically, not the office, is advised that their patient is on the list. If I was the person in Collie and did not want anyone to know, I would not confess to having a local general practitioner in Collie and thereby I would avoid that risk. That is the way to do it.

Mr M.P. Murray: That is alright if you are not in the system.

Dr K.D. HAMES: Remember, the person has gone somewhere else. If a person does not want to see the doctor they have had for years and years because they do not want him or her to know, they go somewhere else, and the only other doctor who knows —

Mr M.P. Murray: I worry about people not going to seek help.

Dr K.D. HAMES: As I said, when seeking help for addiction, there are lots of other sources that are better to access. If someone seeks help in town in a small place such as Collie, five minutes later everybody will know, so they would want to go somewhere else.

Mr R.H. COOK: As I said, I have two concerns about this clause. The second concern relates to subclause (1)(b)(iv).

Dr K.D. Hames: Do you have lots of further questions on this clause?

Mr R.H. COOK: No. As I said, this is my only other concern.

Dr K.D. Hames: All right. The plan is that we will shut down after we do this clause. If this clause is an easy one to deal with, we will start the rest when we come back in a couple of weeks.

Mr R.H. COOK: Cheers. Subclause (1)(b)(iv) states —

> if the CEO considers it to be in the best interests of the drug dependent person's health to do so—any other person whom the CEO considers may be requested to supply a drug of addiction to, or prescribe a drug of addiction for, the drug dependent person.

This comes back to the member for Collie–Preston's question. If a drug-dependent person in Collie or Geraldton comes to the attention of the CEO, it would make sense for the CEO to feel obliged, knowing that this person has been put on the register, to tell the primary caregiver of that person—the doctor—and also the doctor who put that person on the register, if that is a different doctor. The CEO would then make a decision. He would say, "Look, I don't want this person to go doctor shopping anywhere else in Geraldton", so conceivably the CEO could inform all the other doctors in the district that this person is on the register of drug-dependent persons. The member for Collie–Preston's concern is that it will go viral after that. There is a potential for leakage. This subparagraph actually allows for that; it is specifically designed for that. Can the minister describe why this subparagraph is necessary? It is self-explanatory, I suppose. It says, "We want to give your name to anyone else we think you're going to go to." How does that weigh with the concern of the member for Collie–Preston, which is that other people in the community will find out that this person's name has been put on the list?

Dr K.D. HAMES: I am advised that this provision is in the bill to provide the opportunity for the department to notify people who have already given prescriptions to that patient. In situations in which a patient has been doctor shopping and the department has a record that this person has already seen 10 other doctors regularly to get drugs, it is reasonable for the doctors who have looked after that person to know that that person is an addict. That seems reasonable to me; otherwise, having given a prescription once before, a doctor is likely to do it again. If the person is worried about leakage, they are pretty well leaked already if they have been to four other doctors in the town and have got the same stuff; those people already know. One would expect those doctors not to have leaked, as it is called, but they have already had the opportunity to do that because they have already been prescribing drugs of addiction to that person. The department would go to those people, whether they are pharmacists or doctors, who have provided those medications to the patient to let them know that this person has been put on the list of drug addicts.

Debate adjourned, on motion by **Mr J.H.D. Day (Leader of the House)**.