MEDICINES, POISONS AND THERAPEUTIC GOODS BILL 2013

Consideration in Detail

Resumed from 25 September.

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

Debate was adjourned after the clause had been partly considered.

Mr P. ABETZ: Clause 97 relates to health professionals who reasonably believe that a patient of the practitioner is a drug-dependent person. I understand from a medical practitioner that this provision is already in the act. Some years ago, a survey of medical practitioners was carried out by the Department of Health, and the medical practitioner to whom I referred thought that the results of that survey showed that virtually no-one was reporting a drug-dependent person to the health department and that the overwhelming view of medical practitioners was that they did not feel comfortable with reporting those people. Can the minister shed some light on why this provision is in the bill when it is not being followed in practice in the existing act? Could the minister outline why we are perpetuating something when there seems to be a consensus that it is not a good idea?

Dr K.D. HAMES: I do not agree with the contention by the member that doctors are not reporting people who come under this clause. I certainly did when I was working as a medical practitioner. I think the member for Eyre would probably still report someone who comes under this clause to the health department. As we know, there are 14 000 people on the list. About 400 people are put on that list each year by doctors reporting in Western Australia. That does not agree with the member's contention that people are not reporting. Perhaps the person that the member has been talking to has influenced his views on that matter.

Mr P. ABETZ: Let us take, for example, the Fresh Start clinic in Subiaco, which has treated some 8 500 people over the years. If a drug addict walks in off the street and says, "I'm done with drugs; I want to get off. Can you give me a Naltrexone implant or whatever", is that person a drug-dependent person? The difficulty is that many of the people who go to such a clinic are very reluctant to have their name recorded anywhere as being a drug addict. Some of the people who go there are prominent lawyers from the city of Perth, doctors and others and they are very wary of having their name recorded somewhere. I guess one could argue that because a person comes in and says they want to get off drugs, from that point they are no longer a drug-dependent person. Would that therefore exempt the doctor from having to report such a person?

Dr K.D. HAMES: The practitioner at the Fresh Start clinic does report everybody. There have been ongoing discussions with him about that. It is done in a very cooperative manner and not in a manner that seeks to punish or even force people to be reported. As I have said in this house before, I do not always report people and I make that judgement myself, depending on why the patient comes to me and what I believe the outcome needs to be. If they come to me for drugs of dependency, I certainly do report them. If the reason for them coming to me is coincidental on their dependency, then I do not. Maybe I should. The legislation probably requires that I should but I make that judgement myself and take that risk myself. What is critically important is what is in the best interests of patients, and the health department recognises that and works with them. The reality is that it would be better if the clinic practitioner, George, reported people. The member talks about prominent lawyers and other people but, again, the list is not a publicly available document. We talked yesterday about issues of notification, and we are happy to deal with those issues. When we get to that clause, we will talk about how to reduce the risk of other people finding out through the notification process. A person in George's program is, in my view, in the best possible place to get treatment. As I have said to this house before, if I had a child addicted to heroin, that is where I would send them because I think that program is excellent. George knows that I have been very supportive of his program in a number of different ways in the past. It would be better if he reported everyone who goes there just to ensure that they do not then go off and subvert his treatment by having treatment elsewhere. Remember, he is not giving them narcotics; he is giving them the opposite of narcotics, but he must work with those people in the proper way. The health department will continue to work with George to make sure that he goes through that process and gets it right. I therefore think that it is the correct thing to do.

Another issue is about the best way to manage these patients. Doctors need to make the decision themselves on how to look after the patients under their care and how to make sure they are protected in the best way. That is what the health department is there for. We want people to be healthy. We do not want people to be on drugs and addicted to drugs. This whole system is designed to minimise the risks to the general community of people becoming addicted to drugs; and if they are on drugs, to help them get off. That is why we as a government, as the member knows, have put an enormous amount of money into George's clinic to assist him in continuing the work he does; and we will continue to work with him to make sure he does the right thing.

In reality, was I doing the wrong thing in not reporting some of those patients? Maybe I was. Looking back from where I am now, I would probably do it differently and make sure that I followed the requirements of this law.

That is because there is no downside to me in doing that. I can think of one patient who had been a drug addict for a long time and who went through periods of trying to get off the drug. Sadly, I do not think George's clinic was around in those days, but I think she would have benefited enormously from that program. Remember, the law requires doctors to be absolutely convinced that the patient is a drug addict to register them as such. I discussed before with the member for Eyre that it is not always possible to be 100 per cent sure whether someone is an addict.

Mr P. ABETZ: Following up on that, the penalty in the current Misuse of Drugs Act for failure to report, if I remember correctly, is $1 000. In this bill it is up to $15 000.

Dr K.D. Hames: We have already discussed that and we will move later that it be reduced to $5 000.

Mr P. ABETZ: That is excellent. Is there also a potential term of imprisonment penalty?

Dr K.D. Hames: No.

Mr P. ABETZ: That is not in this bill?

Dr K.D. Hames: No.

Mr M.P. MURRAY: Having heard the minister's contribution, my question is: although the Misuse of Drugs Act 1981 is more than 20 years old, is the minister quite comfortable leaving it in place instead of modernising—in inverted commas—the legislation? I certainly subscribe to some current Australia-wide drug addiction programs. People running those programs are saying that the last thing we need to do is put extra pressure onto people with a drug addiction because they will not seek help. Yet here we are leaving penalties in the legislation. I do not quite get the minister's reasoning when he says he could have been fined on many occasions, although I am not sure who checks the checker and how a doctor can be found out and fined. The minister himself said that at times he did not put somebody on the register, but now he has the opposite view. From my reading on the subject, that should be regarded as a lesser issue. The minister is saying that he would now report 100 per cent of the time. I am very confused about what the minister has said to us about his position as a doctor. I know that doctors mature differently in areas of their profession. However, from what I have read, and I have read extensively about drug addiction and how to manage it, one strong view is that we should not be fining someone for seeking help or fining doctors because they do not dob a person in for seeking help.

Dr K.D. HAMES: There are two issues here. One is we need to recognise that the rate of drug addiction and overuse of drugs is not going down; it is going up and is increasing significantly. Many more people are on drugs, many more are doctor shopping and many more are seeking substitutes for drugs. As I am sure the member knows, it is becoming almost an epidemic. I have a note with me from Victoria titled "Spike in prescription drug deaths prompts call for more education", which reads —

> A drug expert say the rate of deaths caused by prescription drug overdoses in Victoria is alarming …
>
> Figures from the Victorian Coroners Court show 176 Victorians died from drug overdoses in the first half of 2013 …

That is just in Victoria where 176 people died.

It is an interesting argument to say that after all this time we should be changing the legislation and improving it when earlier in debate on definitions under "Terms used" members wanted to do the opposite and keep the old definition in place. The reality is that this legislation will change in two ways. One will be an increased transparency in the list, as patients will now have to be told that they are on the list, whereas they did not have to be told before. It is critically important that a patient be told. Previously, I as a doctor might have put somebody on the list and that patient would not know they were on the list. That is therefore a critical change. Of course now we are adding to schedule 4 drugs such as Valium, Stilnox and the like that are in that overuse category. Changes are therefore being made. We are reacting to an increased problem being faced in the community of drug overdose and an increased risk of harm to patients through drug addiction—or self-abuse, which is really what it is—and we need to modernise ourselves to make sure we have a better management practice in place.

Mr R.H. COOK: I want to go over a couple of things the minister said today in this discussion. One thing he said was that at times he does not refer patients —

Dr K.D. Hames: In the past.

Mr R.H. COOK: In the past, yes. The minister talked about the Fresh Start program and said that the practitioner registers or refers some patients but not all. The minister also said that doctors themselves need to make that decision. What are we legislating for in this bill? Is this a guideline or is this a mandatory reporting mechanism?

Dr K.D. HAMES: I think I am used somewhat too much as an example when I answer members' questions. The reality is that it is not a guideline; it is mandatory. We do want doctors to report. The reality is that now if I as a doctor do not report, the right thing will be for the health department to come out to me and say, "Look, you need to be doing this." That is what the procedure will be. As I have said to the member, in the past I might not have done that, but the reality is that in those early days of my practice, I would not necessarily have recognised the importance of doing that. What do we gain by doing that? We ensure that that person is known to be an addict so that if other doctors have to deal with that patient, they do it with the knowledge that that patient is addicted to drugs and they will not just administer those drugs. I did not deliberately not report that patient; I probably did not know at the time that I needed to report that the patient was an addict. I knew she was an addict; she told me that she was an addict. We were trying to work through with her some mechanisms to get her off the drugs, and I have to say that it was not working too well. She had lots of emotional issues. But she could have gone to another doctor down the street who did not know that she was an addict and got injections or whatever from that doctor. I think it is critically important that we stop that sort of behaviour. The right thing for me to have done was to report her. As I said to the member for Collie–Preston, if I were in that same situation again, that is what I would do. This legislation requires people to do that. We have to make sure that GPs know that that is a requirement. We need to let them know that if they are convinced someone is a drug addict, they must make sure that they put that person's name down.

Mr R.H. COOK: The minister is saying that it will now be mandatory.

Dr K.D. Hames: It was mandatory before.

Mr R.H. COOK: Indeed, but the minister is saying that it was essentially—for want of a better description—abused before, and now it will be mandatory. The member for Southern River has left the chamber. There will be an expectation for Dr George O'Neil, for instance, or any other addiction specialist to refer every patient who comes to them.

Dr K.D. HAMES: "Refer" is clearly not the right term. I am sure that the member did not mean "refer". He has to report the name. Yes, that is the requirement. It is the requirement now. I have a note—I am not sure that I understand it exactly, but I will read it—that states that, for a heroin addict reported as drug dependent, information would be used only if a doctor wanted to then prescribe that person a schedule 8 medication. The information would be used, but I do not understand by whom. It has no bearing on any other non–schedule 8 treatment for drug dependence or other medical conditions. It will not affect the treatment or the management, but the reality is that he will still have to do that reporting, just as he had to do before. George knows that. Rather than going down the punitive route of taking George to court to enforce it, the department has for some time been working on that, and George is coming on board with the requirement to do that. If we had left the fine at $15 000, we might have made George a little more cooperative! Nonetheless, that is the requirement. We need to discuss with George the importance of doing it, but also he needs to be confident of the confidentiality of that system, so that when the lawyer whom everybody knows goes in there, he knows that the risk is minimal. That person will still have to front up at his clinic, be seen by people at the clinic, get treatment and keep coming back. It is difficult sometimes to keep those things quiet. I have to admit that I was with somebody just recently at the office of a psychiatrist who works nearby and a person I know very well from the health department was there with their daughter. I never would have suspected. They were obviously surprised to see me and I was surprised to see them. Now we mutually know that someone in the family has issues that need to be dealt with in that way. People obviously have different ways of managing it. Another note states that George's patients can and do go elsewhere or can and do go back to using drugs. We have to make sure that if they go back to using drugs or seek alternative drugs elsewhere, they remain within the system so that people know and do not inadvertently give them medication that they should not have.

Mr R.H. COOK: Going back to the minister's scenario from when he was practising, if that patient came to him now and said, "Dr Hames, I'm not feeling very well. I think I know the reason for that. It's because I'm a drug a—", would the minister at that point say, "No, stop; if you're about to tell me that you're a drug addict, I should let you know that I'll be reporting you to the Department of Health"? Is that the scenario that the minister would foresee now that, firstly, this will be declared mandatory and, secondly, it will be enforced regardless? Perhaps there will be a sign on a doctor's desk stating, "If you tell me you are a drug addict, please be warned that I will be required to report you to the department".

Dr K.D. HAMES: No, I would not stop doctors from saying that and warning people in advance. I firmly believe that having someone who is a drug addict on the register is in their own best interests. I would tell them. I would have to judge the veracity of the statement—whether they were telling the truth. I would have to be certain that they were a drug addict. I might say, "I'm sorry, but I have to let the department know that you are a drug addict." The person would then be notified. I would tell them they will be notified. They would have the opportunity to deny that. They might say, "I was only joking" because I would have no evidence that they were in fact a drug addict. We have no ability, other than through the police, to stop them from getting access to

illegal drugs, and that is almost certainly what they would have been using, rather than schedule 8 drugs or similar. If it is a schedule 8 drug, it is very important for them to be on that list. If they are not on the list because they are getting illegal drugs, they will continue to do that and, hopefully, the police will deal with that. But I do not want them to have the opportunity to get other schedule 8 drugs or similar from other doctors.

Mr R.H. COOK: Does the minister not think that that situation might give cause for some difficult conversations with a patient?

Dr K.D. Hames: Absolutely.

Mr R.H. COOK: They might say, "Dr Hames, I came to you because I trusted you. Now I've got a letter from the director general of Health telling me that I'm on some sort of bloody list." According to a 2004 survey of New South Wales GPs, 63.7 per cent had experienced some level of violence in the previous year. Does the minister not think that the mandatory requirement for GPs to report patients, who do not know that their actions will land them on this list, will give rise to further issues of aggression or violence between the doctor and the patient? After all, they go to the doctor for help and the doctor has set them on this journey to be on the register. Does the minister not think that that will put doctors in a very difficult position?

Dr K.D. HAMES: There are two issues. Firstly, there is no obligation on the doctor to tell the patient that they have done that. If they fear for their safety, they may well keep their mouth closed, but the patient of course will find out and perhaps come back later. That is the risk that doctors run all the time, but not just from that sort of patient. Doctors get patients seeking drugs. The biggest risks to their safety are from two types of patients. The first are schizophrenic patients, who can become angry, abusive and aggressive; and the second are people to whom we refuse to give drugs. That is probably the most common. People go in with all sorts of reasons why the doctor needs to give them a drug. The doctor then finds out that they are on the drug abuse list, or often the doctor decides no, he will not give them a drug. They may go in wanting morphine, and the doctor offers them Panadeine or Panadeine Forte as an alternative to help them get through pain. Patients can become aggressive and abusive. The doctor is there on their own, and normally female staff are at the front of the surgery. It is a risk that doctors take. I have to say that no-one has ever had a crack at me but, as the member said, lots of doctors have experienced that. But lots of professions run the risk of abuse and violence—for example, council rangers who deal with dogs and so on, and people who do Homeswest evictions. I would imagine they are particularly prone to that sort of thing. It is one of the risks of being —

Mr R.H. Cook: Except that the tenant probably knows that they are about to be evicted. This person does not have any idea what is about to happen to them.

Dr K.D. HAMES: Yes, so they can have more people there to make sure that they have strength in numbers. I would not want to be working for Homeswest doing evictions. People take risks in professions; that is the nature of the game.

Mr R.H. COOK: We have made our point around that issue, so I will move on.

Dr K.D. Hames: We are still on clause 97, aren't we?

Mr R.H. COOK: Yes. There are a lot of issues in clause 97.

Dr K.D. Hames: It's only a short clause.

Mr R.H. COOK: I know, but it is an interesting one, and it is certainly the clause in this legislation that provides us with the most concern. One of the issues I want to discuss is the concept of reasonable belief in relation to the decision that a health professional has to take. For the information of members, the old regulations refer to a medical practitioner who, in the course of his practice, becomes aware of, or suspects, that a person is addicted to drugs. The new wording is —

> An authorised health professional who reasonably believes that a patient of the practitioner is a drug dependent person …

We have already mentioned in this place so far that no-one has ever been convicted under the current regulations. I wonder whether the minister would clarify for us what he means by "reasonable belief". So far today the minister has said that the doctor should be absolutely sure before he or she reports a person for the register. That is clearly not the intent of the legislation, because it uses the concept of reasonable belief. Therefore, can the minister tell us what he means by "reasonable belief"?

Dr K.D. HAMES: There are three points to make. One is that similar terminology is used in other jurisdictions. As a result of that, there have been a number of cases in which the concept of reasonable belief has been tested by the courts. In the case of Reeve v Aqualast Pty Ltd [2012] FCA 679, the Federal Court stated that the test of reasonable belief is that "there must be some tangible support that takes the existence of the alleged right beyond mere 'belief' or 'assertion' by the applicant".

Dr G.G. JACOBS: I just want to clarify, firstly, how many practitioners—I really think this is important for the minister's and my colleagues—have been prosecuted under the pre-existing act in recent times.

Dr K.D. HAMES: The answer is nil; no doctors have been prosecuted.

Dr G.G. JACOBS: I think this pertains to the member for Kwinana's question about what is reasonable or what is considered to be a medical practitioner reasonably believing. I will put a scenario to the member. In 25 years of medical practice, it may be that I should have reported a patient who was subsequently proved to be a drug addict. The fact is that no prosecutions have occurred, and the minister said that it is mandatory for a medical practitioner to report such a patient, and it has been mandatory because it was in the pre-existing act. A practitioner would find it almost impossible to show that they reasonably believed. In their defence, the practitioner could say that at the time of their clinical assessment and their clinical appraisal of the particular patient, they reasonably believed that the patient did not have an addiction. I suggest to the member that there would not be a jurisdiction that could prove that the practitioner reasonably believed, because the practitioner falls back on the fact that whichever jurisdiction says the practitioner did reasonably believe was not there; it did not know the clinical setting; it did not know the clinical situation. Therefore, I suggest to the member that the fact that there have been no prosecutions means that it is almost impossible for a case to be brought against a practitioner to show that they reasonably believed that the person was an addict.

Mr R.H. COOK: Perhaps while the minister confers, I will also make comment on that, because I think the member for Eyre has made a very crucial point. It comes down to the issue that this legislation is essentially inserting itself into the conversation that the practitioner had with that patient. From that point of view, it is trying to provide some legal boundaries or a framework for that conversation. As the member and the minister have eloquently demonstrated in the course of the debate on this legislation, it is a very subtle, difficult conversation that at times requires the medical practitioner to make a call. I guess this comes down to the point that we have been trying to make; that is, we are essentially taking the responsibility for making that call away from the doctor. We defend the right of the minister to create laws around this particularly difficult issue, but we are struggling to work out how this clause will undertake what the minister says it will achieve. I have an amendment, member. I do not know whether it will shed any light on it or anything like that. But perhaps I will allow the minister to respond to the member's remarks.

Dr K.D. Hames: You might as well move the amendment.

Mr R.H. COOK: I just do not want to be rude; that is all.

Dr G.G. JACOBS: There is one scenario that I will put to the Parliament that prevents this clause from being a totally toothless tiger. We talked earlier about Fresh Start and George O'Neil. As I said in Parliament some years ago, George O'Neil's Fresh Start program may in fact turn out to be the gold standard in the treatment of heroin addiction.

Mr R.H. Cook: I remember you making that remark.

Dr G.G. JACOBS: Yes, because the member for Kwinana was at me about that. It was when I was sitting over on the front bench. The member for Kwinana asked a lot of mental health questions then; he does not have the opportunity to ask them now.

Mr R.H. Cook: I am not the shadow minister anymore, more's the pity.

Dr G.G. JACOBS: The member would not have a minister in this place to ask those questions of anyway.

There could be one scenario. We talked about people coming off the street to George's clinic and whether he reports all the patients who come to his door. We might say that, no, he does not report all the patients who come to his door because he might reasonably believe that they are not all drug addicts. As the minister said previously, a doctor does not necessarily reasonably believe a patient even when they say that they are a drug addict. The doctor has to make a clinical assessment of that by taking a good history, examining the patient, doing special tests or whatever. However, in the Fresh Start scenario, if in fact George saw a patient in his Fresh Start clinic, made his assessment and commenced the Fresh Start treatment by inserting a naltrexone implant in the patient, that would be evidence that Dr O'Neil believed that that patient was a drug addict, because if he did not believe he was a drug addict, he would not put an implant in him.

Mr R.H. Cook: That is right.

Dr G.G. JACOBS: This clause is not entirely a toothless tiger, because it actually does mandate it. There could be a very clear case that Dr O'Neil reasonably believed that this patient was a drug addict. I commend the minister for this being mandated. I have to say that as a practitioner, I believe that this has been very weakly administered over the past 25 years. The use of the term "reasonably believes" is the only legal reach that this provision could have, because otherwise it would stand very much between the patient and the doctor and that assessment, and that has to be preserved.

There are a few other things that I would like to mention under this clause around the time frames et cetera. It is really important that if this is going to be in the legislation, that the clause does not stand between the patient and the doctor's assessment of that patient. It is important, though, that this is administered. The question I have is: who is this administered by and how is it administered? For example, if I see a patient and say that they are not a drug addict but they turn out to be a drug addict, who pulls me up and says, "Hang on, Dr Jacobs, you saw patient X last week, last month or three months ago and we now reasonably believe that —

Mr R.H. COOK: I am very interested to see where the member for Eyre is taking this line of inquiry.

Dr G.G. JACOBS: I will try to land it somewhere! I hope the member for Kwinana understands where I am going.

Mr R.H. Cook: No; that is why I gave you more time.

Dr G.G. JACOBS: That is why he gave me some more time! For example, I see patient X in my rooms and make an assessment. With the clinical information that I have at the time, the assessment I make is that this patient is not a drug addict. However, if that proves to be wrong and the patient is a raving drug addict, who is watching? Who is monitoring? Who will say, "Dr Jacobs, you saw patient X last week but you didn't report this patient." The patient then went to practitioner X or Y down the road and it subsequently transpired that this person has an addiction. How does that land? Who says to me, "Hang on, Dr Jacobs, you didn't report this patient. You had 48 hours to do it but you did not report that patient, so we are going to prosecute you"? I have an issue with the 48-hours provision as well.

Dr K.D. HAMES: Two of the people who are responsible for that are sitting with me at this table on my left and on my right. That responsibility comes under the Pharmaceutical Services Branch, which is also responsible for the administration of this legislation. The branch does tell doctors off, although there have not been any prosecutions. I have to say that I have been told off. Now that the member has raised that issue, I recall being told off in the past. I had been convinced that a patient was genuine and I gave that patient a narcotic; this was not a reporting issue but was about administering something. That, of course, went to the department. The department saw that I had given something to someone who was a registered drug addict. They called me up said, "You know that patient is a drug addict." I said, "No, I didn't." For some reason I had not called or was not able to get through. The member for Eyre knows what it is like; doctors are sometimes an hour behind in surgery and someone has cut themselves and the doctor has to stitch them. The doctor just wants to get on with it, and sometimes the doctor just accepts the word of a patient when perhaps they should not. I have been told off. I recall that happening on one or two occasions in the past. They do it a lot. They write to doctors every day who have prescribed restricted medication. I believe they should take more action—I have just said that to my advisers—particularly, as I said before, as there are individual doctors in some practices to whom drug addicts know they can always go to get stuff. It may not be narcotics; it might be just Valium when they are trying to see themselves through. The doctors virtually ask them how many they want and prescribe large amounts. Even though some doctors know that they will be sold off, they seem to not have a care in the world and will just do what is prescribed. I think the department needs to be more aggressive in dealing with some of those practices, and I have said that to them.

Mr R.H. Cook: Particularly GPs in Halls Head.

Dr K.D. HAMES: Not necessarily any down near me, but long-term patients have told me that their friends have told them that if they want to get something, all they need to do is go to a particular practice and they will get it for sure. I have heard that story on a number of occasions.

Dr G.G. JACOBS: That is okay, minister. I have been warned as well, but I have been warned because I have given a prescription to a patient who is already on the list. They rang me up and said, "Doctor, did you know that you prescribed medication that was not appropriate? This patient is on the list." That is not exactly what I am talking about. I am talking about a patient who comes to me who is not on the list. This issue is about reporting people so that they do go on the list. A patient who is not on the list comes to me and basically I make the clinical assessment that they are not a drug addict.

Mr R.H. Cook: It wouldn't be a clinical assessment; you just have to have reasonable belief.

Dr G.G. JACOBS: That is right, and I have reasonable belief from my clinical assessment, or reasonable belief that they are not a drug addict from my assessment. What mechanism is there to pick this up? I can see where I might get a call from one of these people in front of the minister if I have prescribed something to someone on the list—they see that—but where the person is not on the list, not on the data, and they come to me, this then becomes a retrospective thing. I did not report this person who is a drug addict and the person has gone on their way. What mechanism is the minister using to pick that up? To say, two weeks, four weeks, three months down that track, "Doctor, patient X came to see you; in fact, they might have seen you more than once and you did not believe they were a drug addict and they are; we think you have breached this clause in this act." I would like to

know—in a practical sense, because I am a practical person and I have been in this situation—how is that picked up? What is the jurisdiction, who administers it, who is the person who believes I should have said this person is a drug addict and who decides to prosecute? I am getting down to the practical nature of how this bill is going to work. The fact that there have been no prosecutions in recent times raises the question of whether this is implementable.

Dr K.D. HAMES: What this legislation does, particularly with the overprescribed section of it, is that it gets in real-time people who are being overprescribed schedule 8 and schedule 4 drugs. It actually makes it a lot easier. The way it would work in practice is that the department would become aware, for example, that someone had gone to five different doctors in a month and gotten MS Contin. The department not only has the list of the medication that the patient was getting, but the doctors they had seen. The department would then go back to those five doctors that prescribed MS Contin maybe two or three times and say, "Look, this person is not on the list but you gave her this drug two or three times. I can tell you that she has gotten it from five other doctors as well and the reality is that you should have put her on the list and had reasonable belief." That is not going to lead to that doctor being prosecuted; it is going to lead to that doctor being more careful next time, more aware and perhaps reporting that patient when he should have. As I have said before, when I was suspicious of patients, even if they were not on the list, I would give their names so if they went to another doctor, that doctor would have some idea that someone else was suspicious of them. If you have five doctors saying they are suspicious and they have all prescribed the same stuff, then clearly there is action to be taken.

We might find that that same doctor—as the member knows, we have not had prosecutions—does not give a damn about who is on the list and just gives them whatever they want regardless. At some stage down the track the department might take the view that it should take the path to final prosecution if the doctor does not modify their behaviour. I think we would find that there would be a fairly quick modification of behaviour, but the alternative is that that doctor may not be able to prescribe that medication anymore.

Dr G.G. JACOBS: If I understand the minister correctly, in the scenario that I gave him before, the only way that the department would come to me is if I prescribed.

Dr K.D. Hames: Yes.

Dr G.G. JACOBS: Right. So if I prescribed an addictive medication once, in my reasonable belief that this person was not an addict, it would not necessarily ring any alarm bells with monitoring and that potentially this could be an issue. If the person came back and I prescribed again and again, that prescribing habit, if you like, of mine would come up on the data and that would be the red flag for someone in the department to say, "Hang on, Dr Jacobs has seen this person one, two, three times. He has given them addictive medication. We reckon that he should have reasonably believed that that patient was becoming addicted." That is the process that triggers the system for me to get the phone call about a patient who was not previously on any record. My question to the minister is: when does that ring alarm bells for him and those people in front of him who are implementing this clause to say, "Oops! We might have a problem here; we reckon Dr Jacobs should know that that patient is addicted"?

Dr K.D. HAMES: No offence, but I think in this whole concept, the member for Eyre is probably small fry. Let me explain: in the sense that there are 720 000 prescriptions for schedule 8 drugs each year, the member and I are both small fry in the numbers that we would prescribe or use in our practice. We are not the big issue. What the department will do is look at all of those; it flags those—Medicare over-servicing is the same sort of issue—in the highest use bracket and looks at those who are the worst risk. So it would not be us. The scenario that the member described—where he might do it three or four times—is true, but the reality is, what is the option for that patient? Clearly, in the member's view, the patient needs that medication, is not registered yet and so is not necessarily yet an addict, but may become one with the member's frequent prescriptions.

Dr G.G. Jacobs: But when does that occur?

Dr K.D. HAMES: The department will see those. The member is not likely to be in the headlights because he is not going to be —

Dr G.G. Jacobs: If I prescribe every week for six weeks in a row I will be.

Dr K.D. HAMES: Sure. That patient should be on the list but may well need that medication and the member will still be able to prescribe that medication. He would be authorised as the doctor who is looking after that patient's medical condition. As the member knows, that person may have a disc prolapse and requires that medication, so the member would be authorised to continue the controlled use of the drug by that patient. What it stops them doing—the doctor should register them because that stops them—is going to the competition, the other doctor down the road, and getting the same stuff again. It may be that they are doing the same thing simultaneously to however many general practitioners there are in Esperance. There has to be mechanisms to

stop that sort of behaviour but there has to be proper treatment management regimes as well, and the department has the responsibility of authorising the doctor to keep prescribing that medication. It is the member's medical decision that that is what the patient needs to treat their condition. Are we going to beat this to death?

Dr G.G. JACOBS: We are going to, because I think it is actually quite important.

Mr R.H. Cook: I agree.

Dr K.D. Hames: You were just shrugging your shoulders.

Mr R.H. Cook: I agree that it is important.

Dr G.G. JACOBS: He said it was.

Dr K.D. Hames: Shrugging his shoulders was his first reaction and then he supported your interjection.

Mr R.H. Cook: I was shrugging my shoulders to your suggestion that we were going to do it to death.

Dr G.G. JACOBS: I shrug my shoulders, too. I am not really offended by any of this, but the minister did say that I was small fry. This is about a potentially drug addicted patient before a doctor. I suggest that it is about small fry. This is about an individual issue and relationship, and a doctor's clinical assessment whether he believes that a patient is addicted. It does come down to a one-on-one situation. I have a practice in Esperance. I do not turn up, but I have doctors there who would be very interested to know how this works. Minister, what is the prescribing threshold that puts up the red flag to say, "Hang on, this patient has been seeing Dr Jacobs. He prescribed some addictive medication the first time, and when they came back in a week later he prescribed it again." From the doctor's assessment, that person was not addicted, rightly or wrongly, and then the patient comes back and the doctor prescribes again. What triggers the implementation system to say, "Hang on, Dr Jacobs should have reasonably believed that that patient was addicted and he had 48 hours to do it and he did not do it?"

Dr K.D. HAMES: What triggers the department to look is if doctors overprescribe what is generally regarded to be a required amount of drug for a patient—to control medication. For example, with MS Contin, I am told that might be one prescription a month. People who become addicted to that generally require a lot more, and in time they become desensitised and their requirement increases. Therefore, it would be when people get to the stage at which it would seem that the patient is seriously addicted to that drug by getting above the amount. It may be triggered by getting more than one prescription from more than one doctor or a doctor prescribing above the accepted medical use of a particular drug for that patient. If that patient saw the member for Eyre and that patient were given a script once a month, it would not trigger any bells. But if that patient was given four prescriptions a month, it certainly would.

Dr G.G. JACOBS: Essentially, an assessment like that evolves—it can take some time, whether it is believed that those thresholds or triggers have been active because of the prescribing quantity. Why then do we have the 48-hour time frame? I want to ask about the 48 hours. The minister may say that a 48-hour provision is already in the legislation. However, I suggest, firstly, that 48 hours—two days—is quite a short time for a busy doctor, and I argue that the minister's people should take time to make an assessment of whether they believe there is a problem here. Why is the practitioner not given time to determine whether there is a problem? The minister says that a doctor should have reasonably believed that a person was a drug addict and should have told us within 48 hours. I would like to tease out some details of the 48 hours. The bill is saying 48 hours from when the belief is formed, when it states —

> (2) A report must —
>
> (a) be made to the CEO within 48 hours of an authorised health practitioner …

I do not know why "authorised health practitioner" is included. Surely, the only people we are talking about are doctors. This politically correct stuff takes out doctors. Who else would be involved in this space?

Dr K.D. Hames: Nurse practitioners.

Dr G.G. JACOBS: Come on! Nurse practitioners prescribing these medications?

Dr K.D. Hames: In remote locations, yes.

Dr G.G. JACOBS: Come on!

Dr K.D. Hames: They do.

Dr G.G. JACOBS: For a very small subset of practice, we take out doctors.

Dr K.D. Hames: I said that I was small fry as well, don't forget, so don't take it personally.

Dr G.G. JACOBS: The minister should be ashamed of himself for taking out "doctor".

The clause states —

> (2) A report must —
>
> (a) be made to the CEO within 48 hours of an authorised health practitioner forming a belief that a person is a drug dependent person;

I suggest, firstly, the reason no prosecutions will occur in this area is that it will have to be proved that a doctor reasonably believed a person was a drug addict. That will be a hard gig, because a doctor could say in defence, "You were not there. You did not know the clinical situation surrounding that. You did not know the background of the patient. You did not examine the patient. You do not know the home situation." The doctor could defy the prosecutor to say that he should have or he reasonably believed. That is the case unless it was the Fresh Start scenario, whereby George sees a patient who obviously believes he needs a naltrexone implant. That is tangible; it can be seen and proved. But this clause requires proving what a doctor thought or did not think, or what a doctor did or did not assess—and that is a pretty hard gig.

Secondly, this clause will be very hard to implement because a report must be made to the CEO within 48 hours of an authorised health practitioner forming a belief. It could be said: Dr Jacobs formed a belief on Tuesday that that patient was a drug addict and by Thursday he has not reported it, and the legislation has been breached.

Dr K.D. HAMES: I was going to recognise the students the member for Murray–Wellington brought into the gallery, but they have long since gone during that presentation by the new shadow Minister for Health! The member for Eyre, who is trying to assist with the passage of legislation, is growing more vehement by each clause.

Mr R.H. Cook: This is the bill that he highly commended today.

Dr K.D. HAMES: That is right. Two points, member.

Dr G.G. Jacobs: I will get hauled out of here shortly.

Dr K.D. HAMES: The Leader of the House is here, so I think we are about to have a division, called on by the member for Eyre!

As the member for Eyre would know, this is a requirement under the current act. But, more importantly, there have been no complaints from any doctors about the requirements of that time period. It requires a phone call. There have been no prosecutions—not even complaints. No doctor is saying 48 hours is unreliable because they are in a busy practice. Maybe they do not report; nevertheless, that is not an unreasonable time period. All it takes is a very brief letter. It would take less than one minute to write a letter to the department that the staff could send saying, "I hereby notify you that it is my belief that such-and-such a patient is addicted to a particular drug." It can also be done by way of a phone call. There is also a standard form available to doctors to fill out. How difficult is that form? It is an easy form. I have one here. The form is entitled "Notification of Addiction to Drugs". It states —

> This is to notify you pursuant to the Drugs —

So that is already in there —

> … that I, within forty-eight hours of the date of this notice, have become aware or suspect that the person whose name and other particulars are set out below is addicted to drugs …

Then the name, address and occupation—presumably "not applicable" could be put there—have to be filled in. As does date of birth, drug or drugs of addiction, how taken—so smoking, oral, injection et cetera—estimated period for which any drug of addiction has been taken, whether the addiction is due to medical treatment, and the name of the doctor giving the notice, and then it is signed. It would take 30 seconds to fulfil that requirement, so I do not regard it as onerous. There is no compelling reason we can see to change it, despite the compelling arguments the member has put forward.

Debate interrupted, pursuant to standing orders.

[Continued on page 4724.]