Speech By

Joseph Kelly

MEMBER FOR GREENSLOPES

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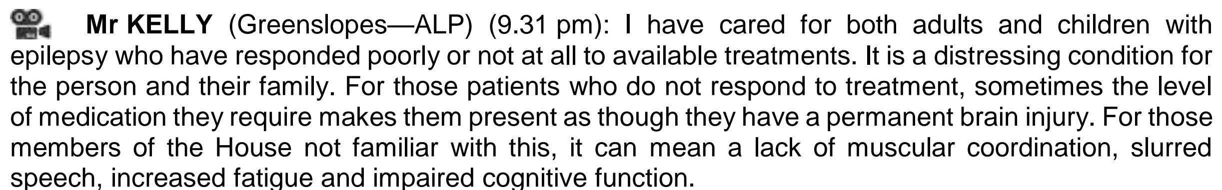
PUBLIC HEALTH (MEDICINAL CANNABIS) BILL



Mr KELLY (Greenslopes—ALP) (9.31 pm): I have cared for both adults and children with epilepsy who have responded poorly or not at all to available treatments. It is a distressing condition for the person and their family. For those patients who do not respond to treatment, sometimes the level of medication they require makes them present as though they have a permanent brain injury. For those members of the House not familiar with this, it can mean a lack of muscular coordination, slurred speech, increased fatigue and impaired cognitive function.

Watching someone have a seizure every few minutes is disturbing, even for an experienced healthcare professional. Watching someone enter status epilepticus, a life-threatening condition where a seizure continues until medical intervention or death, is not something I will ever forget. Nor will I forget the promising young volunteer in his early 20s I worked with many years ago who, like many young people, was studying, working on weekends, had a girlfriend and found time to volunteer with adults with intellectual disabilities. Nor will I forget attending his funeral after his epilepsy caused a seizure while he was in the shower and he fell face down in the bath and drowned.

I have cared for people with multiple sclerosis at every stage of the disease. I have had to feed, dress and toilet people who are mentally sharper than me but who have such bad muscle spasticity they are no longer able to perform those basic functions. I have cared for patients with cachexia caused by AIDS, cancer and other diseases. For those unfamiliar with that term, it refers to a severe muscle-wasting syndrome characterised by weight loss, fatigue, weakness and a severe loss of appetite. Sometimes it feels like you are literally watching someone disappear before your eyes.

I have cared for people with acute and chronic pain, both nociceptive and neuropathic pain—pain that has been caused by burns, cancer, long-term alcohol abuse, multiple sclerosis, stroke, diabetes, kidney stones, spinal injury, eczema, cardiac problems, penetrating injuries and, most frustratingly of all, sometimes for no identifiable reason.

Ask any nurse and they will tell you that night shift is a very lonely time. It never gets more lonely than when you have a patient who cannot sleep due to pain or some other condition that will not respond to treatment. When everyone else has gone and the distressed family members have been coaxed to go and get some rest, you are left alone with the patient, trying to offer comfort and care for someone who cannot find peace. There is nobody to call and nothing left to offer but human kindness, sympathy and company—nothing left but to try to help the person get to the next day with the promise of perhaps an improvement in their condition or a new approach that brings relief.

I do not share these stories from my own practice seeking any personal accolades. Sadly, these stories are not exceptional or unique. Every healthcare professional could share them. Like every healthcare professional and rational compassionate human being, if I could stop people suffering in these ways today I would have wanted it done yesterday.

I have described some tough situations for nurses and healthcare professionals, but our distress is nothing compared to the distress of the person affected and the family and friends who love them. It would be extremely distressing being a parent of a child who has frequent life-threatening seizures or a person whose partner can never find peace from pain. The people in these situations face this reality every day and I fully understand why they are desperate for relief.

This bill, for me, has been a journey. I will admit to being quite sceptical about the benefits of medicinal cannabis. I have read over the years the claims made about the health benefits cannabis can offer. Like most health professionals, my view has always been that if any substance can be used ethically and evidence has proven it to be effective to treat the cause or symptom of a disease, then we should make that substance available and we should use it. If we think something might work, we should research it properly and gather the evidence to allow us to make that determination as to whether it could be used by evidence based health practitioners.

Earlier in my speech I described four conditions. There is strong evidence that medicinal cannabis products can reduce spasticity in late-stage MS. There is a growing body of evidence that it may be effective in treating certain forms of drug resistant epilepsy, cachexia in patients with AIDS and pain. As the member for Toowoomba South noted, recent studies have added to that list. As a health professional I would say that we should make this product available for the conditions where there is evidence that it works and make it available for research where the evidence is growing. The bill does that, and that is why I support it.

However, as I said, at the start of this process I had some hesitations. This process for me started long before I was elected. I have been thinking about these issues and dealing with policy discussions in relation to them for many years. First, as I said, I was concerned that the evidence was not strong; however, I now believe that the evidence is strong in some cases and growing in others. The member for Buderim is a passionate advocate on this issue and I was sad that he left the committee before the inquiry began. We had several discussions about why we simply cannot use the anecdotal evidence that has been gathered by the people who are already using cannabis medicinally. I am not a researcher, but I would imagine that this data could potentially be used; however, it may have many problems. For a start, we could not control the quality or content of the product, the conditions of the patients or other treatments they may be receiving. We would also use valuable research resources gathering and analysing this data instead of setting up properly controlled trials. I put this question to Dr Finn of the Australian Medical Association, and he drew an analogy with methadone, which was first used by non-medical practitioners in New York City. After reports of efficacy grew proper research was done, and that medication has been added to the treatment options for addiction related health conditions.

With a background in health economics, I always think about the opportunity cost and ask in relation to any new medicinal product: what does it do that is not already done; does it do it more effectively, more safely or more efficiently; and if we choose to develop one medication, what other medication are we not developing? In the case of medications for pain relief, I wondered why we would need yet another medication for pain. We already have a vast array of pain medications, and I have personally administered doses of pain relief well above the limit that normally would ease pain and still had those patients reporting pain. In other instances I have cared for people whose conditions should be causing extreme pain but who seem to get by with little or no medication or any other pain-relieving interventions. If we choose to invest resources into researching another pain medication, perhaps we will forgo the opportunity to find the treatment for another condition or disease for which there is no treatment. The same could be said for cachexia, where nutrition can be maintained using nasogastric feeds, PEG feeds or total parenteral nutrition. However, the same cannot be said for drug resistant epilepsy.

I discussed these issues with Dr Jeannette Young during the course of the inquiry and she advised that there is a solid base for pursuing research in all of these areas without resources allocated to do so. In that sense my concern in that area is well satisfied. My other main concern relates to the manner in which medicinal cannabis has been made available in various parts of the world, particularly in the United States. The approach in that country varies considerably, but in many places the approach seems to be very unscientific and does not involve a rigorous medical scientific methodology. In effect, the medicinal tag has been used to justify the recreational use of cannabis. I know that the debate about the recreational use of cannabis and other drugs is active, ongoing and important and I personally think it is a debate that will happen in this parliament at some point in the future.

However, I have deep problems with health and medicine being used as a mechanism to introduce the recreational use of cannabis. If society wants to debate and do that, then we should debate and do that. However, in my view, medicinal cannabis should be considered, regulated and managed in exactly the same manner as every other medication available to evidence based health

practitioners. That is why I was disturbed by the provisions of this bill that required criminal history checks for patients before they could be approved to be prescribed medicinal cannabis. I understand the heightened concern over this drug, but as a health professional I could think of no other situation where I would ask a patient's criminal history before offering treatment. This would have presented a significant ethical issue for health professionals and I am glad that the minister has responded to these concerns and is amending this section of the legislation. With this provision removed, I believe this bill will make medicinal cannabis available to people, both patients and health practitioners, in a manner that will facilitate treatment and research.

I also want to address a few other issues raised during the inquiry. Many submitters suggested that we should allow the personal growing of cannabis, self-administration and establish a testing regime. We already have well-established regulations and processes for medications relating to their research, development, approval, manufacture, transport, storage, prescription, dispensing and administration. We also have regulations and processes for managing those situations where damage occurs to a person because of a problem at any point in that chain from research to consumption of a medication. This system protects consumers first and foremost but also maintains the important scientific integrity.

The resources required to replicate this system for the personal use and growth of any product would be immense and impractical. I asked Dr Jim Finn about establishing a specialised testing regime for one particular product. He stated that he felt it would be more efficacious and cheaper to supply people with pharmaceutical grade product rather than requiring them to grow their own. Many submitters also suggested that cannabis is only effective in the whole plant form. I put this to Dr Jennifer Martin, who made a private submission to the inquiry and who has extensive experience in clinical pharmacology, including all aspects of pharmaceutical design, development, clinical use, regulation and addiction medicine. In her response she talked about the therapeutic products isolated in fish and red wine and stated that there is evidence that whole food consumption of fish particularly is more beneficial than the isolated therapeutic products. With regard to cannabis, she stated that there is a theoretical reason why the whole plant may be more beneficial to the patient but that the evidence is not yet available. However, there is research being conducted by her team in New South Wales and others around the world and I believe we must keep an open mind on this issue, and I note that this bill will assist in enabling this research.

I share the concerns of many submitters relating to the potential time delays occurring between the point at which a doctor recommends a patient use medicinal cannabis and when that use actually occurs. I have seen many new products introduced in my career and things are initially frustratingly slow, but they get faster with time. I raised many questions on this issue with witnesses during the inquiry and I am satisfied that the system, once started, will move faster as these medications become a part of the normal treatment options available to patients and health practitioners. However, I do think it is important that it is reviewed specifically as part of the review that is to be conducted by the health department after two years.

I want to thank all of the people who made submissions and appeared as witnesses and my fellow committee members. I pay particular tribute to those people who are suffering from various diseases or are caring for someone who is suffering from a disease. I sincerely hope that this bill will provide some capacity for those people to obtain relief from the symptoms that affect them and their families. I hope medicinal cannabis works for the conditions I described at the start of this speech and for many others. I want people to get relief from symptoms and I want researchers to answer more questions about other diseases and about cannabis. I want what I have always wanted: I want people to stay healthy in the first place, but if they get sick I want them to get better or I want to be able to relieve their pain or other suffering. This bill represents an important step in achieving that goal and I commend it to the House.