WORKERS COMPENSATION COMMISSION

STATEMENT OF REASONS FOR DECISION OF THE APPEAL PANEL IN RELATION TO A MEDICAL DISPUTE

Matter Number:	**M1-6574/18**
Appellant:	**Amanda Tziallis**
Respondent:	**Elephant Boy Trading Co Pty Limited**
Date of Decision:	**7 August 2019**
Citation:	**[2019] NSWWCCMA 108**

Appeal Panel:	
Arbitrator:	**Catherine McDonald**
Approved Medical Specialist:	**Dr David Crocker**
Approved Medical Specialist:	**A/Prof Michael Fearnside**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 21 May 2019 Amanda Tziallis lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Michael Davies, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 3 May 2019.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - the assessment was made on the basis of incorrect criteria,
    - the MAC contains a demonstrable error.

3. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out, being that the MAC contains a demonstrable error. The Appeal Panel has conducted a review of the original medical assessment but limited to the grounds of appeal on which the appeal is made.

4. The Workers compensation medical dispute assessment guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the Workers compensation medical dispute assessment guidelines.

5. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* ed 1 April 2016 (the Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

RELEVANT FACTUAL BACKGROUND

6. Ms Tziallis was employed by Elephant Boy Trading Co Pty Limited (Elephant Boy) as a chef. On 17 January 2005, she suffered an injury to her back when she reached out to stop a large commercial mixer falling off a bench.

7. On 8 September 2006, Ms Tziallis and Elephant Boy entered into an agreement under which she was paid compensation for 7% whole person impairment (WPI) in respect of an injury to her lumbar spine.

8. In 2018, Ms Tziallis claimed further permanent impairment compensation in respect of an injury to her thoracic spine also suffered in the incident on 17 January 2005, based on an assessment of 31% WPI assessed by Dr P Teychenné in respect of her thoracic spine and central and peripheral nervous system. The claim was disputed

9. In a Certificate of Determination dated 8 March 2019, a Commission arbitrator found that Ms Tziallis suffered an injury to her thoracic spine on 17 January 2005. Based on the case law, the arbitrator declined to determine the nature of the thoracic spine injury.

10. The AMS diagnosed a back strain with subsequent development of central sensitisation. He assessed Ms Tziallis in DRE thoracic category 1 which results in a WPI assessment of 0%. He considered that she had a normal range of movement, no muscle spasm and no neurological findings

PRELIMINARY REVIEW

11. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Workers compensation medical dispute assessment guidelines.

12. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because the AMS has not made a demonstrable error and there is sufficient information in the file to deal with the appeal.

EVIDENCE

13. The Appeal Panel has before it all the documents that were sent to the AMS for the original medical assessment and has taken them into account in making this determination.

14. The parts of the medical certificate given by the AMS that are relevant to the appeal are set out, where relevant, in the body of this decision.

SUBMISSIONS

15. Both parties made written submissions. They are not repeated in full, but have been considered by the Appeal Panel.

16. In summary, Ms Tziallis, through her solicitor, submitted that the AMS had erred in failing to read and/or comment on the entirety of Dr Teychenné's opinion, that he had failed to provide "lawful reasons" in rejecting Dr Teychenné's opinion, that he failed to undertake an adequate assessment of the thoracic spine and that he was influenced by Ms Tziallis' lack of complaint about the thoracic spine when presenting to doctors.

17. Ms Tziallis submitted that the AMS did not undertake the same tests as Dr Teychenné and did not explain why that was not required. She said that the summary provided of Dr Teychenné's report was short and unfair and that the AMS ignored the second report containing the reasoning in support of the diagnosis of incomplete spinal cord lesion.

18. She submitted that the consideration of previous diagnoses was irrelevant and that the AMS was not required to look at the historical documents but merely conduct an examination on the day. She submitted that the diagnosis of her condition was delayed until Dr Teychenné's examination and that previous doctors ignored or misunderstood her symptoms.

19. In reply, Elephant Boy submitted that the AMS took a detailed history and performed an examination of her thoracic spine. He had regard to the material provided to him, including those of Dr Teychenné and provided appropriate reasons in support of his assessment. It submitted that the AMS is not required to record his review of every document submitted. A difference of opinion is not the basis for an appeal.

FINDINGS AND REASONS

20. The procedures on appeal are contained in s 328 of the 1998 Act. The appeal is to be by way of review of the original medical assessment but the review is limited to the grounds of appeal on which the appeal is made.

21. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 the Court of Appeal held that the Appeal Panel is obliged to give reasons. Where there are disputes of fact it may be necessary to refer to evidence or other material on which findings are based, but the extent to which this is necessary will vary from case to case. Where more than one conclusion is open, it will be necessary to explain why one conclusion is preferred. On the other hand, the reasons need not be extensive or provide a detailed explanation of the criteria applied by the medical professionals in reaching a professional judgement.

22. The AMS took a detailed history of the mechanism of the incident – a far more detailed history than that in either of Ms Tziallis' statements. He described the treatment she has undergone, her present symptoms, the previous motor vehicle accident, her work history and her current functioning.

23. The AMS undertook a physical examination and said:

> "Ms Tziallis is very symptoms focused and made a number of comments indicating fear avoidance and concern that her condition is going to get worse over time and that she will end up in a wheelchair.
> …
>
> The spinal curvatures are preserved. There is no tenderness in the thoracic or lumbar spine to palpation. There is no muscle spasm in the thoracic or lumbar region. Forward flexion brings the fingertips to the upper shins, limited by pain in the lower back. There is a good range of lumbar extension but she reports a feeling of unsteadiness. Lateral flexion to each side brings the fingertips to the lower third of the thigh, limited by pain in the lower back. She is able to walk on her toes and her heels and can squat and rise from squatting without assistance. The Trendelenburg test is negative.
>
> Ms Tziallis was able to get up onto the examination couch without assistance. Tone, strength and sensation in the lower limbs are normal. Lower limb reflexes were absent except for the left ankle reflex. Examination of the trunk showed normal sensation, intact abdominal reflexes and a normal range of thoracic spine movement, with no asymmetry.
>
> She has a normal gait. There was intermittent tremor in the right leg during the formal examination."

24. The AMS reviewed a series of investigations, all of which relate to the lumbar spine. His diagnosis was that Ms Tziallis "suffered a back strain and has subsequently developed central sensitisation." He considered that her presentation was consistent with the history and clinical findings but repeated that she was symptom focused.

25. The AMS assessed Ms Tziallis in DRE thoracic category 1 which results in 0% WPI. He said that he had taken into account:

> "There is no tenderness or muscle spasm in the thoracic spine, she has a normal range of movement and there are no abnormal neurological findings. I also note that there is no mention of thoracic spine pain in any of the medical reports available to me and no record of any abnormal findings in the thoracic spine."

26. The MAC template directed the AMS to make brief comments on other medical opinions submitted by the parties and to set out where his opinion differed. With respect to Dr Teychenné, the AMS said:

> "A report from Dr Teychenné in April 2018 makes some reference to tightness in the lower torso and back but there is no record of any restricted movement or muscle spasm in the thoracic spine and no record of any radicular findings in the thoracic region. He diagnoses an incomplete upper thoracic cord lesion. He places Ms Tziallis in DRE thoracic category 3, with 15% WPI."

27. The AMS noted that neither the other medical reports nor Ms Tziallis' statements referred to a thoracic spine injury.

28. The reference by the AMS to a report dated April 2018 is incorrect. Dr Teychenné provided two reports dated 2 August 2018 and 28 November 2018. In his first report, Dr Teychenné described his examination and diagnosis:

> "On examination, she had some imbalance when standing her feet together and pushed, she fell back and she required a catch. She had a 15° decrease in extension of the lumbar spine. She experienced stretching pain over L4/5 at intensity 4/10 up to 6/10, extending into the left and right paralumbar region and loin on movement of the lumbar spine. She had an·extensor left plantar response, the right plantar response was flat. She had 1+ patellar reflexes. I did not elicit any weakness in the upper limbs but in the lower limbs she had probable myelopathic weakness in dorsiflexion of the toes and eversion of the right foot as well as myelopathic weakness in the left and right hip flexion, particularly in right hip flexion. She had a sensory level to pain, temperature and touch sensation associated with sacral sparing. The level was at T2 anteriorly and at T7 posteriorly. Straight leg raising on the right side induced a sharp, pulling, knife-like pain within the right lower abdomen and then she experienced an electric shock into the right buttock at intensity 7/10. This was exacerbated by dorsiflexion of the right foot. She felt a tremor over the inner aspect of the right leg, the tremor extended from the right lower abdomen precipitating a rush to the bathroom. She stated that if straight leg raising had been done repetitively then after three straight leg raises she would have had urine and faecal incontinence associated with a sharp electrical shock-like pain into the right buttock and down the right leg. Her clinical history was consistent with a spinal lesion and her clinical examination results were consistent with an upper thoracic spinal lesion. The restriction in straight leg raising in the right side was not inconsistent in my experience with an incomplete spinal cord lesion. Straight leg raising precipitating urinary and faecal urgency and potentially incontinence, if repeated, was not inconsistent in my experience with a spinal lesion. That is, an incomplete cord lesion. The sensory level indicated the incomplete cord lesion was within the upper thoracic region. It was apparent from history that the incomplete upper thoracic cord lesion had occurred as a result of the injury on 17 January 2015."

29. Dr Teychenné provided an assessment in respect of Ms Tziallis' thoracic spine in DRE thoracic category III. He also assessed Ms Tziallis in respect of the central and peripheral nervous system. That matter is not addressed in the parties' submissions.

30. The arbitrator discussed the issue in the following terms in the Certificate of Determination.

> "[Elephant Boy] made a submission that if I was satisfied that the applicant had sustained an injury to the thoracic spine but not an incomplete central spinal cord lesion, which has been the specific diagnosis of only Dr Teychenne, then the referral to the AMS should not include an assessment of impairment of the central and peripheral nervous system. I do not agree with that submission. Whether a strain or sprain of the thoracic spine, be it permanent or transitory, has led to an incomplete central spinal cord lesion within the thoracic spine is, in my view, and consistent with the decisions of *Bindah* and *Jaffarie*, within the province of the AMS when the AMS comes to assess the permanent impairment of the applicant resulting from an injury to the thoracic spine.
>
> [Elephant Boy] submits that it would be open for me to make a finding as to whether or not the applicant did sustain an incomplete central spinal cord lesion. I am of the view that this specific diagnosis is best left to the expertise of a medical opinion in the assessment of permanent impairment that is to be made by the AMS."

31. The referral was made in respect of injury to Ms Tziallis' thoracic spine. Consistently with the authorities referred to by the arbitrator, the AMS was required to determine the nature of that injury because the nature of the injury was a medical dispute within the meaning of s 319 of the 1998 Act. In *Bindah v Carter Holt Harvey Wood Products Australia Pty Limited*[1] Meagher JA said[2]:

> "The language of order 3 supports the conclusion that the 'injury' being referred to was the trauma injury and its pathology. In terms, it is a determination that the applicant 'suffered injury on 28 January 2009'. That injury was a trauma injury, aspects of the pathology of which were in dispute and remained to be assessed. The medical dispute as to that pathology was, by order 3, to be assessed under Pt 7 of Chapter 7 of the WIM Act."

32. Emmet JA said[3]:

> "Consequently, Order 3 of the Certificate of Determination on 21 November 2011 simply recorded the arbitrator's determination that Mr Bindah had incurred **an** injury. That determination involved a conclusion on a matter of causation, being that Mr Bindah's employment was a substantial contributing factor to his injury. The arbitrator did not need to make a determination about the precise nature of the injury, because that matter fell within the province of a medical dispute, which was for the approved medical specialist, and, if necessary, the Appeal Panel, to determine. The arbitrator's determination that Mr Bindah had suffered an **injury** meant that he had suffered an injury according to the definition of that term in s 4 of the Compensation Act. That definition includes both a personal injury and an aggravation, acceleration, exacerbation or deterioration of a disease. It was then for the approved medical specialist to determine the degree of permanent impairment that **resulted from the injury**. That determination involved a conclusion on a matter of causation, as indicated by the words in bold."

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[1] [2014] NSWCA 264.
[2] At [26].
[3] At [119].

33. The AMS was required to determine if the injury which Ms Tziallis suffered to her thoracic spine was an incomplete spinal cord lesion. If it was not an incomplete spinal cord lesion, he was not required to consider if Ms Tziallis suffered permanent impairment in respect of her central and peripheral nervous system.

34. It would have been better if the AMS had explained his reasons for disagreeing with Dr Teychenné in greater detail because that would have assisted Ms Tziallis to understand why his opinion differed. However the AMS did provide a brief description of the reasons why he did not agree with Dr Teychenné when he set out Dr Teychenné's findings.

35. A careful reading of Dr Teychenné examination findings reveals that the only symptoms he recorded with respect to the thoracic spine were a "sensory level to pain, temperature and touch sensation around T2 anteriorly and T7 posteriorly" and a "weakly positive left extensor plantar response" which he said was consistent with a thoracic cord lesion. Most of the other signs and symptoms noted relate to the accepted lumbar spine injury. There was no comment as to the level of muscle tone (presence of spasticity) in the lower limbs which would be anticipated to be abnormal in the presence of a spinal cord injury, even if incomplete or partial.

36. There are no reports of radiological investigations of Ms Tziallis' thoracic spine in the file.

37. Dr S R Deshpande was qualified on behalf of Elephant Boy. In his report dated 8 January 2018 he set out his understanding of the four types of incomplete cord lesion. The panel agrees with his summary. Dr Deshpande said:

> "There are 4 acceptable incomplete cord lesions, they are
>
> 1. Central cord syndrome
> This is the most common variety of partial cord lesion and mostly affects the cervical cord seen in hyperextension injuries to the neck and associated with cervical spondylosis. There is paresis in the upper and lower extremities.
>
> 2. Anterior cord syndrome.
> Seen in fractures of the vertebral body or rarely anterior spinal artery thrombosis. There is bilateral motor paralysis, loss of pain and temperature and sensation below the level of lesion.
>
> 3. Posterior cord syndrome
> Causes are trauma or penetrating injury to the spinal cord and multiple sclerosis. There is ipsilateral loss of proprioception, vibration and tactile discrimination below the level.
>
> 4. Brown-Sequard Syndrome
> This is due to trauma or compression of the cord. There is ipsilateral loss of proprioception, vibration and tactile discrimination below the level, contralateral loss of pain and temperature sensation."

38. The Panel notes that the Brown Sequard syndrome is caused by compression of one side of the spinal cord and also causes ipsilateral motor (voluntary muscular) weakness below the level of the lesion.

39. None of those syndromes are relevant to Ms Tziallis' case. There are no convincing clinical findings to support the diagnosis of a partial spinal cord lesion as described above, as found by the AMS when he examined her.

40. The examination findings recorded by Dr Teychenné are not consistent with those of other doctors who have examined Ms Tziallis including the AMS. The spasm observed by Dr Teychenné cannot be explained on an anatomical basis. Dr E Korbel, urologist, considered that Ms Tziallis had not reached maximum medical improvement in the absence of investigations. Investigations were required to confirm the urological diagnoses made by Dr Teychenné because those diagnoses could not be made in the absence on investigations.

41. The AMS did what he was required to do by the Guidelines. He assessed Ms Tziallis as she presented on the day of the examination and exercised his clinical judgement in making a diagnosis. He took a detailed history to enable him to understand the complaint she made. He undertook an appropriate examination and did not observe tenderness or muscle spasm in her thoracic spine. He found a normal range of thoracic spinal movement and no abnormal neurological findings in the lower limbs. On the basis of his examination, the only appropriate assessment was to place Ms Tziallis in DRE thoracic category I.

42. The AMS noted that Dr Teychenné did not record restricted movement or muscle spasm and made no record of radicular findings.

43. It is necessary to deal specifically with the submissions made on Ms Tziallis' behalf.

44. The reference to *Dogon v Redmond* [4] is not apposite because that decision concerned the failure of an original assessor to explain his conclusion, in breach of the relevant Motor Accident Authority Guidelines.

45. An AMS is required to report his findings and set out his opinion which the AMS has done in this case. He was directed by the form to comment on the reports of other practitioners and to set out where he differed. The absence of previous complaint by Ms Tziallis in respect of her thoracic spine is relevant, as is the absence of any radiological investigations. The submission that the AMS was not required to look at the historical documents is inconsistent with the submission that he was required to provide detailed comments as to why he disagreed with Dr Teychenné.

46. In *State of NSW v Kaur*[5] Campbell J said:

> "In *Wingfoot Australia Partners Pty Ltd v Kocak* [2013] HCA 43; 252 CLR 480, the High Court of Australia dealt with the nature of the jurisdiction exercised by a medical panel under cognate Victorian legislation. The legislation is not entirely the same but it is broadly similar in purpose. Allowing for some differences, the High Court said at page 498 [47]:
>
> > 'The material supplied to a medical panel may include the opinions of other medical practitioners, and submissions to the Medical Panel may seek to persuade the Medical Panel to adopt reasoning or conclusions expressed in those opinions. The Medical Panel may choose in a particular case to place weight on the medical opinion supplied to it in forming and giving its own opinion. It goes too far, however, to conceive of the functions of the panel as being either to decide a dispute or to make up its mind by reference to completing contentions or competing medical opinions. The function of a medical panel is neither arbitral or adjudicative: It is neither to choose between competing arguments nor to opine on the correctness of other opinions on that medical question. The function is in every case to perform and to give its own opinion on the medical question referred to it by applying its own medical experience and its own medical expertise.'

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[4] [2010] NSWSC 1329

[5] [2016] NSWSC 346 at [25]-[26].

Not all of this, as I have said, is apposite in the context of the New South Wales legislation. In particular it is obvious that approved medical specialists are required to decide disputes referred to them by the process of medical assessment. Even so, it is not necessary that approved medical specialists should sit as decision makers choosing between the competing medical opinions put forward by the parties. Essentially, the function is the same as that described by the High Court in *Wingfoot Australia*. That is to say, their function is in every case to form and give his or her own opinion on the medical question referred by applying his or her own medical experience and his or her own medical expertise. It is sufficient, as their Honours pointed out at [55], that:

> 'The statement of reasons… explain the actual path of reasoning in sufficient detail to enable the Court to see whether the opinion does or does not involve any error of law.'"

47. The AMS disclosed his path of reasoning as he was required to do, even if his discussion of Dr Teychenné's opinion was in short form.

48. Ms Tziallis also submitted that the examination was inadequate on the basis that the injury was an incomplete cord lesion. The AMS did not agree with that diagnosis and, on the basis of the medical evidence, the Panel does not consider he was in error. The AMS has explained why he considered Dr Teychenné was wrong by setting out his examination findings. If Ms Tziallis had suffered an incomplete spinal cord lesion the AMS would have observed signs and symptoms of the kind described at [37] above when undertaking the examination that he described.

49. For these reasons, the Appeal Panel has determined that the MAC issued on 3 May 2019 should be confirmed.

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

A MacLeod

Ann MacLeod
Dispute Services Officer
As delegate of the Registrar