WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-6369/19**
Appellant:	**Mileva Rujak**
Respondent:	**Glad Cleaning Services Pty Ltd & Ajax Cleaning Services Pty Ltd t/as ADZ Cleaning Services Pty Ltd**
Date of Decision:	**7 July 2020**
Citation:	**[2020] NSWWCCMA 123**

Appeal Panel:	
Arbitrator:	**Jane Peacock**
Approved Medical Specialist:	**Dr Frank Machart**
Approved Medical Specialist:	**Dr Robert Kuru**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 15 April 2020 Ms Mileva Rujak (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. Dr Ian L Meakin, orthopaedic surgeon and Approved Medical Specialist (AMS) issued a Medical Assessment Certificate (MAC) dated 19 March 2020 in respect of the Appellant's whole person impairment. The AMS assessed the appellant's permanent impairment of the back, neck, left elbow, right knee, left leg at or above the knee. Dr Meakin issued a MAC dated 19 March 2020. Dr Michael J Rochford, Urologist and AMS, assessed the appellant's loss of sexual function and issued a MAC dated 19 March 2020

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. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground(s) 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).

PRELIMINARY REVIEW

6. 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.

7. As a result of the Appeal Panel's preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination.

EVIDENCE

Documentary evidence

8. 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.

Medical Assessment Certificate

9. The parts of the MACs given by the AMS' that are relevant to the appeal are set out, where relevant, in the body of this decision.

SUBMISSIONS

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

FINDINGS AND REASONS

11. 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.

12. 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.

13. The matter was referred by the Registrar to the AMS as follows:

> "The following matters have been referred for assessment (s 319 of the 1998 Act):
>
> - *Date of injury* — *12 June 2001, due to the nature and conditions of employment from 16 May 2000 to 12 June 2001.*
> - Body parts/systems referred: — Permanent impairment of the back.
Permanent impairment of the neck.
Left arm at or above the elbow.
Right leg at or above the knee.

Left leg at or above the knee.
Loss of sexual organs.

- Method of assessment: Table of Disabilities".

14. Dr Rochford, urologist, was the AMS to whom assessment in respect of loss of sexual organs was referred.

15. Dr Rochford assessed as follows:

Body Part (describe the body part as per Table of Disabilities) e.g. right leg at or above the knee	**Date of injury**	**Total amount of permanent % loss of efficient use or impairment**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Total permanent % loss of efficient use or impairment attributable to this injury** (after deduction of any pre-existing impairment in column 4.)
Loss of Sexual Organs	**11 June 2001**	**10%**	**0%**	**10%**

16. Dr Meakin, orthopaedic specialist, was the AMS to whom the orthopaedic injuries were referred for assessment. The AMS assessed as follows:

Body Part (describe the body part as per Table of Disabilities) e.g. right leg at or above the knee	**Date of injury**	**Total amount of permanent % loss of efficient use or impairment**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Total permanent % loss of efficient use or impairment attributable to this injury** (after deduction of any pre-existing impairment in column 4.)
Permanent impairment of the back	12.06.2001 Due to the nature and conditions of employment from16 May 2000 to 12 June 2001	20%	N/A	20%
Permanent impairment of the neck	12.06.2001 Due to the nature and conditions of employment from 16 May 2000 to 12 June 2001	10%	N/A	10%

Left arm at or above the elbow	12.06.2001 Due to the nature and conditions of employment from 16 May 2000 to 12 June 2001	15%	N/A	N/A
Right leg at or above the knee	12.06.2001 Due to the nature and conditions of employment from 16 May 2000 to 12 June 2001	Nil	N/A	Nil
Left leg at or above the knee	12.06.2001 Due to the nature and conditions of employment from 16 May 2000 to 12 June 2001	15%	N/A	15%

17. The worker appealed.

18. The complaints on appeal relate to the assessments in respect of all the body parts referred.

19. In summary, the appellant submitted that the AMS Dr Meakin erred as follows:

    (a) He failed to have regard to the evidence of the appellant contained in her statement dated 22 January 2020 which included her evidence that she had further treatment to the back, increased pain from her back down her left leg, pain from her back into her right leg, ongoing chiropractic and physiotherapy treatment and need for ongoing pain relief medication. The percentages awarded to her in 2011 have increased as a result of deterioration and the AMS had failed to consider that deterioration and increase the previously assessed percentages is in error.

    (b) The AMS misdescribes the back as the lumbar spine. The AMS has recorded a symmetrical reduction in active Rom due to back pain and then goes onto state that she does not fulfil the definition of radiculopathy. The AMS has incorrectly used the criteria for an assessment of WPI rather than the table of Maims.

    (c) The AMS misdescribes the neck as the cervical spine and has found no neurological impairment or pathology and has equated this to a nil increase in impairment of the neck. This does not follow and is in error.

(d) The AMS used incorrect criteria to assess the left arm by using a goniometer to assesses ROM which is the assessment for WPI not the table of maims.

(e) In relation to impairment of the left arm, the AMS did not question the appellant about difficulties in using her arm as a result of the neck injury. Rather he appears to have assessed the appellant using methodology required for WPI. He found that without pathology there was no increased loss which is an error.

(f) In relation to the legs the AMS assessed ROM of the knees, ankles and toes rather than pain extending from the back down the left and right legs as detailed in the appellant's statement. The AMS has stated on page 5 of the MAC that "she reports no symptoms associated with the right leg at the time of today's assessment," however in page 3 reported that the appellant sated "there is discomfort radiating into the right and left thigh when walking, not more significantly on the left side." The failure of the AMS to consider the earlier recorded history and complaint amounts to a demonstrable error. The AMS also failed to consider the history recorded by Dr Giblin in relation to the right leg, namely numbness in both legs.

20. In summary, the appellant submitted that the AMS Dr Rochford erred as follows:

(a) if there is deterioration in the back pain injury and pain leading to an increased percentage impairment, then it follows that there would be an increased to the loss of sexual organs. Failure by each AMS to consider that the increased lower back pain experienced by the appellant resulted in an impairment of her sex life was a demonstrable error.

21. In summary, the respondent submitted that neither AMS had erred and that the MACs should be confirmed.

22. The role of the AMS is to conduct an independent assessment on the day of examination. The AMS is required to take a history, conduct a physical examination, review the special investigations, make a diagnosis and have due regard to other evidence and other medical opinion that is before the AMS. The AMS must bring his clinical expertise to bear and exercise his clinical judgement when making an assessment of impairment and make such assessment in accordance with the criteria in the Guides.

23. Here the appellant has previously been awarded compensation in respect of each of the body parts referred for assessment in these proceedings. She says that she has deteriorated since the prior awards were made.

24. It is not the AMS' job to assess whether there has been deterioration since the last compensation awarded or percentages assessed. Rather the role of the AMS is to assess permanent impairment as at the day of assessment. Whether that sounds in additional compensation being awarded to the appellant is not a matter for the AMS. The AMS job is not to assess deterioration or further impairment. His job is to assess the degree of permanent impairment on the day of assessment. In this case the assessment is required under the Table of Disabilities given the injury occurred on 12 June 2001.

25. Here the AMS took a history which is broadly consistent with the other evidence that was before him and is recorded as follows:

"(a) Brief history of the incident/onset of symptoms and of subsequent related events, including treatment:

The Applicant is a 59-year old, right-handed woman who states that on arriving in Australia her first job was with the Glad Cleaning Services starting there in May of 2000. She was employed as a cleaner in the offices of Westpac in Sydney. She worked six and a half hours a day Monday to Friday commencing at 5.00pm and finishing at approximately 11.30pm. She states there was a lot of heavy and repetitive work and during this time she noted the onset of back in her low back, posterior neck, right arm and left arm, right and left leg. There was also a history of decreased physical relations with her husband due to back and leg pain which became worse over time and culminated in 2005.

There was no specific injury during her work and she was in her early forties when she stopped working.

The Applicant states that prior to commencing work with her current employer of May 2000 she had no such symptoms in any of these anatomical sites. Her treatment at the time consisted of massage and since ceasing work, she has been in receipt of a Disability Support Pension since 2009. She continues under the care of her local practitioner.

(b) Present treatment:

The Applicant was seen in 2002 by Dr David Rail, neurologist because of bilateral carpal tunnel-type symptoms more noticeably on the right side.

By 2014, he noted there had been paraesthesia in both hands for a period of 10 years. He also noted that she was not diabetic. At the time of examination on 8 August 2014, Dr Rail reported to the local practitioner, Dr Tomasevic of Liverpool that on neurological examination, the Applicant was neurologically intact in both the upper and lower extremities. He noted that the EMG studies that he performed showed bilateral, moderate carpal tunnel syndrome and he treated her with splints.

He also noted the history of neck and back pain and that she was not working at that time. Dr Rail continued and repeated EMG studies noting that the left side had the most dominant symptoms.

The Applicant was reviewed at the request of Dr Tomasevic by Dr J Dave, orthopaedic surgeon in 2014. Dr Dave performed an arthroscopy in 2013 on her knee noting the presence of degenerative change in the medial compartment, but maintenance of a full range of motion.

It was his opinion that her symptoms were consistent with early osteoarthritis of the knee. Surgery was performed at the Fairfield District Hospital. The Operation Report revealed some Grade II changes on the lateral femoral condyle with no major meniscal injury and in intact cruciate ligament. There were some Grade I changes in the trochlear at the time of surgery on 10 September 2013.

The Applicant was referred to see Dr Agus Kadir, orthopaedic surgeon who performed an open left carpal tunnel release in 2017 also at Fairfield District Hospital. Both these surgical procedures did not result in any improvement in her symptoms.

The Applicant also underwent injections into the left knee and the lumbar spine late in 2019 with no improvement of symptoms at either clinical site.

(c) Present symptoms:

The Applicant states that she is currently not working and she does not hold a driver's licence. She describes discomfort in her posterior cervical neck on an intermittent and daily basis. There is also discomfort in the midline low lumbar back. She states that there is discomfort radiating into the right and left thigh when walking, but more significantly on the left side. She states she has to stop after 15 minutes of walking to rest and then starts to walk again. There is also pain in her posterior cervical neck and she also reports discomfort on the pad of the left shoulder. She states that she still has a feeling of partial sensory loss in the left, middle, ring and little finger. She states there is no abnormal sensation in the index or thumb on the left side. She reports no sensory loss on the right side today and she reports no symptoms in her right shoulder. She points to the pad of the left shoulder as the site of some discomfort on elevating her arm.

At the time of examination today, there were no symptoms associated with the right knee. She does describe some discomfort, however, over the antero-medial aspect of the left knee on prolonged weight bearing.

(d) Details of any previous or subsequent accidents, injuries or condition:

It is noted that the symptoms relating to the Applicant's left knee occurred when she fell at the Westfield Shopping Centre on 8 March 2011. She slipped on a piece of plastic injuring only her knee. She was treated by Dr Dave and it was a result of this injury that led to the left knee arthroscopy and debridement on 10 September 2013. There was a successful claim against Westfield and their cleaning contractor at that time. She continues to describe left knee pain. The Applicant also states that at the time of today's presentation there is discomfort in the left thigh but not the right thigh or distal right leg.

(e) General health:

The Applicant is treated for hypertension and depression by her local practitioner. She does not utilise cigarettes or alcohol. There is a previous history of operative appendicectomy, cholecystectomy and a single Caesarean.

(f) Work history including previous work history if relevant:

As stated, she was employed as a cleaner with Glad Cleaning Services since May of 2000. She worked with them until June of 2001. There has been no work since that time and she is in receipt of a Disability Support Pension. She also continues to live off the previous lump sum Workers Compensation settlements that she described as well as the settlement against the Westfield cleaning contractors following her fall and injuring her left knee on 8 March 2011.

(g) Social activities/ADL:

The Applicant was born in Croatia and went to primary and high school in that country. She was married at the age of 20. They have four children with a daughter currently living with them and three other children living separately.

The Applicant migrated to Australia on 11 June 1998 and became an Australian citizen on 19 February 2001. The local practitioner is Dr Predrag Tomasevic. He has been the local doctor since the family came to Australia.

The Applicant lives with her family in a home unit at Liverpool. She states that she has difficulty performing all heavy activities around the home. She states that she continues to take Panadol Osteo, Celebrex, Crestor, Lipitor and intermittent Lyrica under the guidance of the local practitioner. The Applicant states that her daughter helps with cleaning the house, although she does her own cooking. She has never driven a car."

26. The AMS conducted a thorough physical examination and recorded his findings as follows:

"The Applicant is a woman of stated age who walks without a limp and who uses no appliances. She states that she weighs 92kg and stands 173cm tall. On examination of her cervical spine there is an asymmetrical active loss of range of motion with pain restricting terminal range of rotation to the left to two-thirds of normal expected range. All other movement of the cervical spine is to normal range with no evidence of palpable paravertebral muscle spasm or guarding. She describes discomfort on turning to the left. There is no asymmetrical wasting of the right and left shoulder.

At the time of today's assessment, there is a full, measurable range of movement in both shoulders when measured with a goniometer:

On examination of the right and left shoulder when measured with a goniometer the following range of motion is noted:

Shoulder Movements	**Active ROM Measured RIGHT**	**Active ROM Measured LEFT**
Flexion	180º	180º
Extension	50º	50º
Abduction	170º	170º
Adduction	40º	40º
Internal Rotation	80º	80º
External Rotation	80º	80º

There is only discomfort described on the pad of the left shoulder on terminal range of elevation. There is no asymmetrical wasting of the right and left arm or forearm measured at maximum circumference. Both the right and left shoulder are stable to examination and there is no evidence of rotator cuff impingement. All deep tendon reflexes in the right and left upper and lower extremities are symmetrically present and equal today and there are no abnormalities of tone. There is no wasting of hand musculature.

One notes the scar associated with the open left recent carpal tunnel decompression. At the time of physical examination, there is a full range of right and left wrist, hand and all finger and thumb movements.

Examination of sensation reveals a partial sensory loss involving the left middle, ring and fifth finger and the adjacent palmar area. This sensory loss was checked on two occasions.

There was no discomfort in her thoracic spine in which she demonstrates a symmetrical range of motion with no evidence of palpable paravertebral muscle spasm or guarding.

In relation to the lumbar spine, there is a symmetrical restriction of range of motion to two-thirds of normal range with a description of discomfort on terminal range in all planes including flexion, extension and lateral flexion and rotation to the right and left. There is no evidence of palpable paravertebral muscle spasm or guarding. All deep tendon reflexes in the right and left lower extremities are symmetrically present and equal and there are no abnormalities of tone or sensation. She has symmetrically equal right and left great toe power referencing flexion, extension and also subtalar joint eversion and inversion.

There is no asymmetrical wasting in the right and left thigh measured 10cm above the patellae or around the points of maximum circumference of the calves. There is no evidence of measured leg length discrepancy. As stated, there is a negative straight leg raising test in both the supine and sitting position.

On examination of both the right and left knee, there is no local evidence of heat, redness, swelling or patello-femoral crepitus. Both knees are technically stable with a measured symmetrical range of motion from 0º extension to 130º of flexion. There is no abnormality of alignment on weight bearing. There is a full range of right and left ankle and subtalar joint movement and a symmetrical full range of movement of all toes.

On examination of the lumbar back, the Applicant points to the low lumbar back as the site of her discomfort. She reports no symptoms associated with the right leg at the time of today's assessment and there are also no symptoms associated with the right arm.

There were no other findings on examination."

27. The appellant takes issue with the examination conducted by Dr Meakin including the use of the goniometer submitting that is not required for assessment under the table of disabilities. The appellant also takes issue with the extent of the examination findings recorded for the back and neck submitting that his examination is what would be required for WPI assessment and this has led to him making his assessment on the basis of incorrect criteria.

28. The Panel notes that the AMS has conducted a thorough physical examination. He is entitled to rely on his clinical findings on the day of examination. His job is not to make an assessment on the basis of the appellant's self-report. He has taken a history of the appellant's subjective complaints. He must make his assessment using his clinical judgment. A thorough physical examination is necessary to a proper assessment whether that is under the table of maims or as whole person impairment assessment. He is entitled to rely on his physical findings on the day of examination.

29. The AMS had regard to the special investigations as follows:

> "X-rays of cervical, thoracic, lumbar spines and pelvis dated 24 February 2011 reported by Dr Mark Cohen, Liverpool Diagnostics: Minor spondylitic changes noted only in the thoracic and lumbar spines. There is narrowing of the L5/S1 disc space and narrowing of the L2/3 disc space. No abnormalities in the pelvis. There is a slight thoracic scoliosis convex to the right with thoracic discs of normal level. The cervical spine is normal.
>
> Plain x-rays left knee dated 9 March 2011 reported by Dr Mark Cohen, Liverpool Diagnostics: No abnormality noted. Plain x-rays left ankle dated 9 March 2011 reported by Dr Mark Cohen, Liverpool Diagnostics.
>
> MRI scan left knee dated 8 June 2011 reported by Dr Adrian Gale, Rayscan Imaging Liverpool: Comminuted tear of the anterior horn and body of the lateral meniscus – a degenerative meniscal cyst arises from the tear of the body of the meniscus. Medial and lateral collateral ligaments are intact. Anterior and posterior cruciate ligaments are intact. There is a Grade 2 loss of articular cartilage in the medial compartment of the knee consistent with early degenerative change. There are less marked changes in the lateral compartment.
>
> MRI scan of the left ankle dated 8 June 2011 reported by Dr Adrian Gale, Rayscan Imaging Liverpool: Early osteoarthritis noted in the talo-navicular joint; some increased linear signals in the Achilles tendon but without fusiform thickening or evidence of tear – minor Achilles tendinopathy.
>
> CT scan lumbosacral spine dated 6 March 2012 reported by Dr Tom Echer, Ultrascan Imaging, Liverpool: No disc protrusion seen; predominantly right-sided face joint spondylosis at L3/4 and on the right side at the L4/5 level. The vertebral canal and right exit foraminal volumes are in the lower range of normal. There is no left-sided narrowing. At the L5/S1 level there is marked bilateral facet joint spondylosis with hypertrophic facet joints encroaching on the lateral recess but not encroaching on neural structures.
>
> MRI scan of lumbar spine dated 9 April 2017 reported by Dr N Ganeshan, Rayscan Imaging, Liverpool: Multi-level facet joint arthropathy with low grade disc bulges and central canal narrowing at L4/5 and L5/S1 with questionable L4 and L5 foraminal nerve root compression.
>
> Plain x-ray of cervical spine and thoracolumbar spine dated 16 April 2018 reported by Dr Ramesh Cuganesan, Spectrum Imaging, Liverpool: Mild curvature of the thoracic spine convex to the right centred on the T7/T8 level with compensatory convex curve to the left from the T5 to T3 level; moderate degenerative change involving the L4/5 and L5/S1 facet joints. Moderate narrowing of the left C3/4 exit foramina due to facet joint hypertrophy and moderate narrowing of the left C6/7 exit foramina.
>
> MRI scan left knee and lumbar spine dated 4 October 2019 reported by Dr N Ganeshan, Rayscan Imaging, Liverpool: Medial and lateral meniscal tears with Grade 4 chondrosis of the tibial plateau as well as Grade 2 changes of the femoral condyles; tibiofemoral osteophytic lipping; mucoid degeneration of the anterior cruciate ligament with anterior cruciate ligament cyst formation and probable low grade tears. Joint effusion without substantial synovitis.
>
> The scan of the lumbar spine demonstrated discovertebral changes particularly at the lower three lumber levels with severe facet joint arthropathy. There are foraminal osteophytes at L4/5 and L5/S1 bilaterally without clear impingement of the L4 or L5 nerve roots."

30. The AMS summarised the injury and his diagnosis as follows:

> "The Applicant has a history of work injury during the course of her heavy working duties between 16 May 2000 and 12 June 2001. There is no specific injury incident to be described. In that time she described discomfort in her back and neck with pain also over the area of the left shoulder and symptoms suggestive of bilateral carpal tunnel syndrome more significantly on the left side. She also had symptoms of pain radiating into her left thigh.
>
> She has undergone an open decompression of the left carpal tunnel in 2017 with no lasting effect.
>
> It is also noted there was a fall at work during her working duties on 8 March 2011, which does not relate to the current claim. The left knee was treated by Dr Dave with arthroscopic procedures in 2013 with no lasting effect. There is advancing degenerative change in the left knee which does not relate to the work injury outlined between 16 May 2000 and 12 June 2001.
>
> The Applicant also states that she has suffered reduced sexual relations with her husband which is the subject of a more expert report and is outlined later in this document by Dr Edward Korbel, urological surgeon an expert in this field."

31. The AMS explained his assessment as follows:

> "Assessment of impairment is made with reference to the Table of Disabilities, Workers Compensation Act 1987.
>
> Lumbar spine
>
> At the time of today's assessment the Applicant demonstrates a symmetrical reduction in active range of motion of the lumbar spine due to back pain. She does not fulfil the definition of radiculopathy as set out in the current Guidelines at the time of today's assessment referencing the lower extremities.
>
> At the time of today's assessment, the Applicant represents a 20% permanent impairment of the back.
>
> Cervical spine
>
> At the time of today's assessment, there is an asymmetrical active loss of range of motion in the cervical spine with ongoing discomfort. There is no neurological impairment of the right or left upper extremity that is not explained by the diagnosis of bilateral carpal tunnel syndrome, particularly with reference to the left side.
>
> There were only minimal degenerative changes.
>
> Therefore, at the time of today's assessment, the Applicant demonstrates a 10% permanent impairment of the neck.
>
> Left arm at or above the elbow
>
> At the time of today's assessment, the Applicant demonstrates full, stable range of left shoulder movement with evidence of a recent left carpal decompression that made no difference to her stated symptoms. She has a partial sensory loss involving her fingers that do not totally relate to a carpal tunnel syndrome. The left upper extremity is otherwise, neurologically intact.

It is therefore, my finding at the time of today's assessment that the Applicant demonstrates a 15% loss of the efficient use of the left arm at or above the elbow.

Right leg at or above the knee

At the time of today's examination the Applicant demonstrates no clinical symptoms or signs relating to the right lower extremity and there are no objective, physical signs.

I therefore, find no loss of efficient use of the right leg at or above the knee at the time of today's assessment.

Left leg at or above the knee

At the time of today's assessment, there is some continuing discomfort in the left knee due to advancing degenerative changes which relate to a work accident that occurred on 8 March 2011 in the Westfield Shopping Centre.

All ongoing impairment relating to the left leg do not relate to the injury that occurred at work due to the nature and conditions of her employment from 6 May 2000 to 12 June 2001. There is, however, a history of pain radiating from the lumbar back into the left thigh which continues and which has been unresponsive to conservative treatment including selective nerve blocks of the L4 and L5 level under the care of Dr David Rail, a neurologist.

Therefore, at the time of today's assessment, the Applicant demonstrates a 15% loss of the efficient use of the left leg at or above the knee relating to the current work accident."

32. The AMS made brief comment on the other medical opinion that was before him as follows:

"(a) I read with interest the reports of Dr J Dave, orthopaedic surgeon between 2013 and 2014 relating to his treatment of the Applicant's left knee following her fall in a separate work incident in 2011. The left knee demonstrates advancing degenerative change.

(b) I note the various reports prepared by Dr David Rail, neurologist between 14 January 2002 and 31 August 2017. I note his referral to Dr Agus Kadir, orthopaedic surgeon on 8 April 2016 relating to the forthcoming left carpal tunnel decompression at that time.

(c) I read the reports of Dr Sheikh Habib, orthopaedic surgeon on 31 May 2011 to 23 June 2011 and 1 March 2012. These report the ongoing history of left knee pain following the fall in the shopping centre on 8 March 2011. He also notes the ongoing history of lower back pain. On 1 March 2012, he acknowledges the back pain with radiation into the left leg in an L5/S1 distribution.

(d) I have read the report of Dr Edward Korbel, urological surgeon dated 19 October 2010. He assesses impairment at 10% loss of sexual organs relating to the nature of her employment at that time with no specific injury. He notes that at that time the Applicant discussed a loss of libido and decreased sexual function. I note there was no report of bowel or bladder symptoms, apart from some urgency but no loss of control.

(e) I read the report prepared by Dr Sham Rao Deshpande, orthopaedic surgeon on 4 September 2019. His was a short report noting the onset of symptoms relating to the back, neck, left shoulder and left leg as a result of her work and that the Applicant was on a Disability Support Pension at that time and was not working. At the time of his examination, he noted a full range of motion in the right and left shoulder and also noted no neurological impairment in the right or left upper or lower extremity. He noted evidence of some left knee loss of motion and patello-femoral crepitus which was not noted today. Dr Deshpande suggested that the symptoms related to the progression of early spinal degeneration and also known left knee osteoarthritis.

(f) I read with interest the two reports prepared by Dr Peter Giblin, orthopaedic surgeon on 1 November 2010 and 3 June 2019. In his initial report at the time of examination he noted that neither the right nor left shoulder had any evidence of passive adhesive capsulitis but did comment on slight terminal range of restriction in both shoulders. He noted no abnormalities of motor strength or deep tendon reflexes in the upper extremities and also in the lower extremities. He noted some wasting of the calf on the right side as compared with the left side and to a lesser extent in the left thigh. He noted that the left knee was slightly swollen at that time.

He assesses impairment in accordance with the Table of Disabilities for injuries before 1 January 2002 noting the nature and conditions of her work environment from 16 May 2000 to 12 June 2001 as being the attributable period.

I note that Dr Giblin as an orthopaedic surgeon elects to assess sexual organs. In his report of 3 June 2019, he assesses impairments with an increased component in all areas. He notes the constant back pain with burning sensation in the left leg. He notes a history of walking for 20 minutes with the leg becoming numb suggesting a stenotic condition which is not supported by the last MRI scan in October 2019. He noted a full range of motion in both shoulders with no evidence of rotator cuff impingement and no focal neurological impairment in the upper extremities at the time of his assessment. He makes no reference to the carpal tunnel surgery performed on the left in 2017."

33. The Panel can discern no error in the assessment of permanent impairment in respect of each of the body parts assessed by AMS Dr Meakin. He is entitled to conduct the physical examination in the thorough manner that he has done and is entitled to rely on his physical findings on the day of examination. He has not based his assessment on the appellant's self-report alone but has relied on his physical findings after taking proper account of the history, special investigations and other evidence that was before him. The Panel can discern no error in his assessment. As the Panel has stated, his job was not to assess deterioration from prior awards of compensation but to assess the degree of permanent impairment of each of the body parts as a result of the injury on 12 June 2001.

34. Turning then to the complaint on appeal in respect of assessment by AMS DR Rochford of the sexual organs. The complaint in respect of the sexual organs assessment was that "if there is deterioration in the back pain injury and pain leading to an increased percentage impairment, then it follows that there would be an increase to the loss of sexual organs. Failure by each AMS to consider that the increased lower back pain experienced by the appellant resulted in an impairment of her sex life was a demonstrable error."

35. The AMS Dr Rochford took a thorough history which he recorded as follows:

"(a) **Brief history of the incident/onset of symptoms and of subsequent related events, including treatment**:

Although the date of injury is given as 12 June 2001, there was no specific date of an injury. Over a period of several months Ms Rujak found that she was developing low back pain while working as a cleaner. Her job involved collecting rubbish, dusting and vacuuming. She had to collect and lift bags of rubbish weighing approximately 20 kg.

Ms Rujak said she was working under pressure for up to six hours per day. She developed pain in the lower back and down the left leg and since that time pain has been present every day.

Ms Rujak saw a general practitioner who referred her for x-rays and prescribed her medication which included analgesics and anti-inflammatory agents. She was put off work and she has not worked since that time. The low back pain has persisted but is less severe since stopping work.

(b) **Present treatment**: Hydrotherapy twice a week, self-funded and analgesics for pain.

(c) **Present symptoms**: Ms Rujak has pain in the lower back and left leg. Pain occurs several times a day.

(d) ***Details of any previous or subsequent accidents, injuries or condition****: Nil.*

(e) **General health**: Ms Rujak is on Amlodipine for hypertension. She has hypercholesterolaemia and is treated with Crestor and Lipitor. She had post-menopausal bleeding for which she was treated in hospital.

When specifically asked about urinary problems, Ms Rujak said that she has had some urinary problems of incontinence since 2001. She said that when she has an urge to pass urine, she becomes incontinent. This had not been previously told to her general practitioner. She indicated that she has been diagnosed as having a vaginal prolapse and this was diagnosed at the time of her admission to Liverpool Hospital when she was 50 years of age for treatment of vaginal bleeding. Treatment has been advised for her urinary symptoms.

(f) **Work history including previous work history if relevant**: Prior to employment, Ms Rujak did home duties. She has four children.

(g) **Social activities/ADL**: Ms Rujak keeps her own home. She is able to cope if she rests intermittently.

Sexual problems:

Ms Rujak said the pain in the back has produced a problem of loss of libido. She said her emotional state stops her from wanting sexual activity. She now engages in sexual activity only once every two to three months.

She had menopause at the age of 50. She takes naturopathic medications for hot flushes which she has continued up to the present time. She has a problem with vaginal dryness for which the doctor has given her creams to apply."

36. The AMS did not conduct a physical examination or have regard to special investigation as this was not required by him and there is no complaint on appeal about this aspect.

37. The AMS explained his assessment as follows:

> "Ms Rujak has previously been assessed for loss of sexual organs and has received previous compensation. She said that she has continued to decline with increasing loss of libido and loss of interest in sexual activity. This she said is due to her ongoing problems of low back pain.
>
> I would assess that her present ongoing increase in loss of libido is due to her post-menopausal status with problems indicating a problem of atrophic vaginitis for which she is being treated with local creams. She would also experience a natural loss of libido with increasing age.
> …
> History of loss of libido with increasing age. The history of continuing back pain is not requiring active treatment in a major degree I would agree with Dr Deshpande that there has been an age-related deterioration of her cervical, lumbar spine and left knee."

38. The AMS commented on the other evidence as follows:

> "I note that Dr Peter Giblin has assessed a loss of sexual function at 20%. He has not stated any criteria or indication as to how this assessment has been calculated. It is my assessment that any further decline in loss of sexual organs is not due to the original injury."

39. The Panel can discern no error in the assessment by Dr Rochford. He has exercised his clinical judgment after taking a through history from the appellant about her complaints. His job is to assess the loss of sexual organs as a result of injury. He has done this and explained that contribution to the loss of libido that is coming from other factors including aged related factors and post-menopausal status. The panel can discern no error in the assessment by Dr Rochford of 10% loss of sexual organs as a result of injury on 12 June 2001 under the Table of Disabilities.

40. For these reasons, the Appeal Panel has determined that the Medical Assessment Certificates issued by Dr Meakin and Dr Rochford on 19 March 2020 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*.

J Burdekin

Jenni Burdekin
Dispute Services Officer
As delegate of the Registrar