WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

Issued in accordance with section 294 of the *Workplace Injury Management and Workers Compensation Act 1998*

Matter Number: **4914/20**
Applicant: **Gregory Sundstrom**
Respondent: **Able Repairs Gladesville Pty Ltd**
Date of Determination: **18 December 2020**
Citation No: **[2020] NSWWCC 418**

The Commission determines:

1. The lumbar surgery proposed by Dr Al Khawaja, being a fusion of L3 to S1 posteriorly and anteriorly, is reasonably necessary treatment as a result of injury to the lumbar spine on 6 November 2017 sustained in the course of the applicant's employment with the respondent.

2. The respondent is to pay for the proposed lumbar surgery and ancillary treatment pursuant to the applicable workers compensation gazetted rates.

A brief statement is attached setting out the Commission's reasons for the determination.

Josephine Bamber
Senior Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF JOSEPHINE BAMBER, SENIOR ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A MacLeod

Ann MacLeod
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. On 6 November 2017 Gregory Sundstrom sustained an injury to his lumbar spine when he was removing an oven from a van in the course of his employment with the respondent, Able Repairs Gladesville Pty Ltd. The respondent does not dispute this injury occurred.

2. The claim for compensation in these proceedings involves a claim pursuant to section 60 of the *Workers Compensation Act 1987* (the 1987 Act) for the cost of proposed lumbar fusion surgery from L3 to S1 based on the recommendation of Dr Al Khawaja. The doctor has recommended both an anterior and posterior fusion procedure. The respondent has issued a notice pursuant to section 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) denying that this procedure is reasonably necessary medical treatment. The respondent's counsel refined the issues in dispute by conceding that the respondent does not dispute that Mr Sundstrom's symptoms result from the injury on 6 November 2017, so causation is not in issue.

3. The parties agree that, should the Commission find that the proposed lumbar surgery is reasonably necessary treatment, applying the Court of Appeal's decision in *Pacific National Pty Ltd v Baldacchino*, the procedure would involve the insertion of an artificial aid[1] and therefore section 59A(6) of the 1987 Act applies, resulting in section 59A being not applicable to Mr Sundstrom's claim.

PROCEDURE BEFORE THE COMMISSION

4. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

5. The matter proceeded in Arbitration hearing on 3 November 2020 by telephone due to the COVID19 situation. Mr Ross Hanrahan, counsel, appeared for Mr Sundstrom instructed by Mr Wayne Keen, solicitor. The respondent was represented by Mr Phillip Perry, counsel, instructed by Ms Jaclyn Dooley, solicitor and Mr Stephen Mackle from GIO.

6. Both counsel made oral submissions which were sound recorded, and a copy of the recording is available to the parties. A written transcript was made from the sound recording and forwarded to the parties to enable them to check it was a complete record of their submissions because there was a short period during the Arbitration Hearing where I could not communicate with the parties.

7. Mr Perry slightly amended the transcript and his solicitor forwarded the amended copy to the Commission.

8. Mr Hanrahan agreed with those amendments, but also made written submissions referring to various legal authorities. At my request the Commission sent an email to both parties on 27 November 2020 at 1:50pm to ascertain if the respondent wished to make further submissions to address these authorities.

9. On 8 December 2020, the respondent's solicitor, Ms Dooley, advised the Commission that the respondent has no further submissions to make in respect of the applicant's submissions dated 20 November 2020.

[1] [2018] NSWCA 281, *Baldacchino.*

EVIDENCE

Documentary Evidence

10. The following documents were in evidence before the Commission and taken into account in making this determination:

    (a) Application to Resolve a Dispute (ARD) and attached documents;
    (b) Reply and attached documents;
    (c) Amended written transcript; and
    (d) Applicant's written submissions dated 20 November 2020.

Oral Evidence

11. There was no oral evidence.

FINDINGS AND REASONS

12. It is helpful to briefly summarise the relevant evidence before the Commission before considering counsels' submissions.

Mr Sundstrom's statement

13. Mr Sundstrom has provided a statement outlining the circumstances surrounding his injury and the medical treatment he obtained thereafter from his general practitioner, Dr Khan, and neurosurgeon, Dr Al Khawaja. Mr Sundstrom underwent a right L4/5 facet and nerve block on 24 November 2017. He had three sessions of physiotherapy, which he says did not help ease his back pain. On 6 December 2017, Dr Al Khawaja performed another right L4/5 facet and nerve block. Mr Sundstrom says this only helped to relieve his pain for a week or two.

14. Mr Sundstrom states that on 15 January 2018, Dr Al Khawaja performed a right L4/5 microdiscectomy and rhizolysis and he remained in hospital for three to four days.

15. Thereafter, he was referred to an exercise physiologist, Jackie Laffan, and he started having treatment with her in May 2018 including hydrotherapy.

16. Mr Sundstrom says he experienced burning nerve pain from his lower back into his left buttock and leg and so Dr Al Khawaja referred him to have a CT scan of his lumbar spine on 28 August 2018 and a whole body scan on 10 September 2018.

17. Thereafter, on 5 December 2018, bilateral L4/5 facet blocks were performed and on 19 December, bilateral L5/S1 facet blocks were undertaken.

18. Mr Sundstrom says he continued to experience a great deal of pain and as a consequence felt down and depressed and Dr Khan referred him in March 2019 to Regina Tan, psychologist. However, he says he did not see her and Dr Khan referred him to another psychologist who he saw three times.

19. On 19 June 2019, further bilateral L5/S1 facet blocks were performed.

20. Mr Sundstrom says he continues to experience severe lower back pain, with pain radiating into his left lower limb. He states that Dr Al Khawaja informed him that as his condition had deteriorated he recommended an L3 to S1 anterior lumbar fusion and later a posterior fusion. Mr Sundstrom advises:

> "I have continued to follow the advice of my doctor and Specialist. I am in a great deal of pain every day. The pain radiates from my lower back into my left leg down to my knee. More recently I am also starting to experience pain travelling down the right side into my buttock. I have trouble doing simple things on a daily basis. This includes any activities where I have to bend such as getting dressed, putting on shoes and socks, tying up shoelaces, bending to pick anything up off the floor and any other activities requiring bending. I also find I cannot stand for lengthy periods and after about 10 minutes I am in a lot of pain and have to sit down. I still drive a motor vehicle but tend to limit my driving to about 30 minutes. I cannot do any outdoor activities around the house although I do try to water the garden and try to assist inside in the kitchen. I have tried numerous types of conservative treatment including physiotherapy, exercising, hydrotherapy, pain management, medication and injections, however my condition has continued to deteriorate. I wish to have the surgery as recommended by Dr Al Khawaja."

Dr Al Khawaja

21. Dr Al Khawaja reported to Dr Khan on 24 November 2017, so a short time after the injury on 6 November 2017. He noted that Mr Sundstrom had limited spinal movements in all directions. He had a decreased right knee reflex and decreased sensation in the right L4 dermatome. Right L4/5 facet and right L4 nerve blocks were recommended and thereafter physiotherapy[2].

22. The CT scan of the lumbar spine on 1 December 2017 found a posterior right sided disc bulge extending into the right lateral recess and subarticular canal at L4/5. The radiologist stated that this is causing likely right L4 and possibly L5 nerve root compression. He stated the disc did not appear to be calcified. There was bilateral L5 pars defects and significant multilevel facet joint hypertrophy[3].

23. On 21 December 2017, Dr Al Khawaja reported to Dr Khan that the injection helped Mr Sundstrom slightly, but he is still in a significant amount of pain and weakness in his right leg. The doctor recommended a right L4/5 decompression and discectomy[4].

24. On 16 February 2018, Dr Al Khawaja advised Dr Khan that Mr Sundstrom's symptoms had improved after the surgery[5].

25. On 16 April 2018, Dr Al Khawaja advised that Mr Sundstrom had some gluteal pain and difficulty walking for a long time or standing for a long time. The doctor advised Mr Sundstrom to walk and swim and do core muscle exercises[6].

26. The MRI scan dated 23 July 2018 revealed:

> "Post-surgical changes with post-surgical enhancement in the paraspinal musculature at the L3 to L5 level in keeping with recent L4/5 microdiscectomy. There is no paraspinal collection. There is multilevel disc dehydration as described with circumferential disc bulges seen at L2/3, L3/4 and L4/5 and a small central disc protrusion seen at L5/S1. At the L4/5 level, there is no residual or recurrent disc protrusion/extrusion identified although the enhancement in the paraspinal musculature extends anteriorly to abut the right L4/5 facet and also into the right L4/5 neural foramen to surround the exiting right L4 nerve, favouring peridural fibrosis.[7]"

[2] ARD p 27.
[3] ARD p 28.
[4] ARD p 49.
[5] ARD p 51.
[6] ARD p 52.
[7] ARD p 29.

27. On 17 August 2018, Dr Al Khawaja reported that Mr Sundstrom had left gluteal hotness and burning sensation[8].

28. A CT scan dated 28 August 2018 was undertaken to rule out hot spots and facet joint pathology. The radiologist reported there was mild L2/3 disc prolapse and possible right sided compromise of the exiting nerve root at L4/5 level and posterior facet joint degenerative changes at several levels[9].

29. The whole body scan dated 10 September 2018 has a clinical history of pain in the low back radiating down the left leg. The scan showed moderately intense tracer uptake in the facet joint on the left side at L4/5 level of the lumbar spine. There was mild tracer uptake on the right at this side and moderate uptake at L5/S1. Degenerative arthritis was diagnosed[10].

30. On 31 January 2019, Dr Al Khawaja again reviewed Mr Sundstrom and reported to Dr Khan that the injection helped for a short period of time. He proposed ablation and said if that did not work pain management or surgery may need to be considered[11].

31. On 23 April 2019, Dr Al Khawaja again reported to Dr Khan that he needed to wait for the machine to arrive from USA before he could do the ablation procedure and so he proposed more blocks[12].

32. On 20 July 2019, Dr Al Khawaja reviewed Mr Sundstrom and reported to Dr Khan that he was progressing well after the injection but was still annoyed by pain in the back and leg. The doctor recommended for him to keep exercising and doing hydrotherapy[13].

33. On 13 February 2020, Dr Al Khawaja reported to Dr Khan that Mr Sundstrom's condition is deteriorating as he has more pain in the back and legs. He also feels weakness in the legs and bad pain in the left leg. He was depressed and taking medication for that. Dr Al Khawaja records that Mr Sundstrom cannot cope with his symptoms and he would like to have a definite procedure. The doctor recommended a spinal fusion from L3 to S1 anteriorly and posteriorly. The doctor said it is complex surgery and he cannot guarantee it will work. The doctor set out at length all of the potential complications and risks[14].

34. On 6 March 2020, Dr Al Khawaja answered the insurer's query. He said that Mr Sundstrom had tried every type of conservative treatment including physiotherapy, exercising and pain management. The doctor indicated that if the surgery is successful, Mr Sundstrom will require lots of support as well with domestic help, but he will be able to look after himself. Dr Al Khawaja did advise that there is a chance of adjacent segment disease where the L2/3 and L1/2 levels can play up and in that case he may require an extension of the fusion[15].

35. On 17 June 2020, a CT lumbar spine scan found widespread degenerative changes causing central or foraminal narrowing[16].

[8] ARD p 54.
[9] ARD p 32.
[10] ARD p 33.
[11] ARD p 57.
[12] ARD p 59.
[13] ARD p 62.
[14] ARD p 37.
[15] ARD p 39.
[16] ARD p 34.

36. On 2 July 2020, Dr Al Khawaja reviewed Mr Sundstrom and advised Dr Khan (with a copy to the insurer) that he completely disagreed with Dr Casikar's opinion. He states:

> "The reason behind that is that Dr Casikar has not been practising any neurosurgery for a long time, and Dr Casikar is not a Spine Surgeon. The other thing is Dr Casikar has never performed anterior fusion into the spine, so I do not believe a non-practising, non-Spine Surgeon who has never performed such a procedure to be able to comment on the need for surgery or not.[17]"

37. On 8 July 2020, Dr Al Khawaja reviewed Mr Sundstrom again and referred to a CT scan SPECT scan which he said showed a pars defect at the L5 vertebrae but no spondylolisthesis, but he had facet joint injury at L4/5 and L5/S1. Dr Al Khawaja said this could explain his back pain in addition to the disc damage. He recommended blocks to these areas and hydrotherapy[18]. Dr Al Khawaja recommended these blocks for both diagnostic and therapeutic reasons.

38. In addition, in the ARD there are reports from the exercise physiologist, physiotherapist, Ripples Hydrotherapy, Pinnacle Rehabilitation as well as certificates of capacity from Dr Khan. These documents have been read by me, but it is not necessary to summarise them in this decision.

Dr Casikar

39. Dr Casikar is a neurosurgeon who has provided a medico-legal report to the respondent dated 19 May 2020. He did not undertake an in person assessment, it was conducted over zoom for 30 minutes. Dr Casikar diagnosed that Mr Sundstrom has constitutional degenerative disease of the lumbar spine, with a workplace aggravation by the event on 6 November 2017. He adds that it is possible that the workplace incident aggravated the pre-existing compression of the nerve root and the microdiscectomy undertaken by Dr Al Khawaja was appropriate to deal with this.

40. Dr Casikar says that Mr Sundstrom's symptoms have not significantly improved as he has significant degenerative disease of the lumbar spine. He adds that,

> "His sciatic symptoms have reduced; however, there is evidence of ligamental thickening in other segments and facet arthropathy at L2/3 and L3/4. These are probably responsible for his present symptoms."

41. In relation to the proposed surgery Dr Casikar opines it is "unlikely to make any significant improvement". He believes Mr Sundstrom will still have pain even after the fusion and Dr Casikar states that a conservative management of his back pain is a better outcome than surgery. He adds,

> "Mr Sundstrom is able to do some amount of activities, he is able to drive the car and assist his wife. Under these circumstances, spinal fusion is unlikely to make any more spectacular improvement. Indication for the spinal surgery is not related to his workplace aggravation which in my opinion has resolved. His present symptoms are predominantly due to degenerative disease of the lumbar spine."

42. Dr Casikar repeats these comments later in his report and says he finds it "very difficult to support a major 360º fusion on an individual who has retired from work." He says evidence based studies indicate this kind of enthusiastic multisegment fusion has a very poor outcome as far as relief of pain and improvement in lifestyle.

[17] ARD p 65.
[18] ARD p 55.

43. As alternative treatment, Dr Casikar suggests home based exercise, minimal pain medication and weight reduction.

44. Dr Casikar says he has requested Mr Sundstrom to bring to his office his x-rays, so that Dr Casikar can look at them and advise the insurer regarding further clarification of his MRI images pre and post-operative.

45. In the ARD is an email that Mr Sundstrom's solicitor wrote to the insurer on 3 August 2020. It states that Dr Casikar has not been practising neurosurgery for a very long time. He is not a spinal surgeon and has never performed an anterior fusion of the spine. The solicitor asked the insurer to advise whether these matters were correct[19]. The insurer responded that Dr Casikar is a qualified neurosurgeon and independent medical examiner. It did not answer the questions posed about Dr Casikar's experience.

Dr Darwish

46. Dr Darwish is a neurosurgeon and spinal surgeon who has provided a medico-legal report for Mr Sundstrom's solicitors dated 12 August 2020. He reviewed Dr Al Khawaja's reports, the radiological reports and the actual scans and the report of Dr Casikar. On examination Dr Darwish found:

> "Today Gregory complained of lower back pain radiating to the left leg associated with paraesthesia below the left knee. For the pain he takes Panadeine Forte up to six tablets a day, Lyrica 150mg twice a day and occasional Endone.
>
> On examination today, he walked into my rooms with a limp. Straight leg raising test was 80 degrees on the left side with positive nerve stretch test. He had decreased sensation over the lateral and medial aspects of the left leg in the distribution of the left L4 and L5 dermatomes. Muscular power was normal in all limbs."

47. Dr Darwish stated that Mr Sundstrom has tried all forms of conservative treatment and he believes the surgery recommended by Dr Al Khawaja is reasonable however he only recommended a posterior approach for the fusion. He says that he does not think there is any need to do an anterior approach as well. He said there is less risk of morbidity, especially taking into account Mr Sundstrom's age.

48. Dr Darwish adds that he believes the degenerative changes in the lumbar spine are caused by the nature of Mr Sundstrom's employment which requires lifting over many years and the acute disc prolapse at L4/5 is caused by the work-related injury on 6 November 2017.

Determination

Legal Principles

49. The legal test to be applied when determining whether proposed treatment is reasonably necessary as a result of a work place injury as required by section 60 of the 1987 Act was considered in *Diab v NRMA Ltd*[20] wherein Roche DP stated at [86]:

> "Reasonably necessary does not mean 'absolutely necessary' (*Moorebank* at [154]). If something is 'necessary', in the sense of indispensable, it will be 'reasonably necessary'. That is because reasonably necessary is a lesser requirement than 'necessary'. Depending on the circumstances, a range of different treatments may

[19] ARD p 21.
[20] [2014] NSWWCCPD 72, *Diab*.

qualify as 'reasonably necessary' and a worker only has to establish that the treatment claimed is one of those treatments. A worker certainly does not have to establish that the treatment is 'reasonable and necessary', which is a significantly more demanding test that many insurers and doctors apply."

50. In *Diab,* Deputy President Roche cited the decision of Judge Burke in *Rose v Health Commission (NSW)*[21] with approval and stated:

> "[88] In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:
>
> (a) the appropriateness of the particular treatment;
> (b) the availability of alternative treatment, and its potential effectiveness;
> (c) the cost of the treatment;
> (d) the actual or potential effectiveness of the treatment, and
> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.
>
> [89] With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts.
>
> [90] While the above matters are 'useful heads for consideration', the 'essential question remains whether the treatment was reasonably necessary' (*Margaroff v Cordon Bleu Cookware Pty Ltd* [1997] NSWCC 13; (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in *Bartolo*, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression 'no reasonable prospect' should be understood, '[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content'".

51. The decision in *Diab* was applied in *Broadspectrum Australia Pty Ltd v Skiadas*[22]. Mr Hanrahan refers to this decision in his written submissions because it was a case where the outcome of surgery cannot be guaranteed. In *Skiadas* the surgery in question was to the cervical spine and Dr Al Khawaja when recommending it stated, as he has done in Mr Sundstrom's case, the outcome of the surgery cannot be guaranteed. As Roche DP stated in *Diab* at [89] surgery carries a risk of a less than ideal result, however, a poor outcome does not necessarily mean that the treatment was not reasonably necessary.

52. Mr Hanrahan argues that in *Diab* the possibility of pain reduction was said to be a legitimate criterion to consider when assessing the reasonableness of the proposed surgery.

53. Mr Hanrahan also refers to *Sunrise T & D Pty Ltd v Le*[23]. In that case at [101] it was noted that the worker had undergone decompressive surgery and a host of other treatments which had not been successful, however the Arbitrator concluded that there was a reasonable chance of a successful outcome from the proposed surgery and it was better for Mr Le to have the surgery than go without it. On appeal this approach was found not to be in error.

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[21] [1986] NSWCC2; (1986) 2 NSWCCR 32, *Rose*.
[22] [2019] NSWWCCPD 31, *Skiadas.*
[23] [2012] NSWWCCPD 47, *Le*.

54. It was also submitted that the unlikelihood of a cure does not prevent the surgery being found to be reasonably necessary. Mr Hanrahan added that notwithstanding the complexity and downside risks of the proposed surgery, Mr Sundstrom should be entitled to seek treatment that promises to bring about a more permanent relief of his condition. He adds, it is not reasonable to accept Mr Perry's submission that the view of what is clinically needed should be limited to as at the time of this judgment.

55. I accept that the relevant legal principles to be considered include these matters to which Mr Hanrahan has made reference. However, every case turns on its own particular facts and so it is necessary for me to engage with both parties' medical evidence in relation to the proposed surgery that has been recommended for Mr Sundstrom.

Submissions

56. Mr Perry wished it to be noted that on 8 July 2020 Dr Al Khawaja had recommended facet blocks at L4/5 and L5/S1 and this treatment was approved by the insurer on 23 October 2020 in a fax to the doctor and by phone to Mr Sundstrom on 29 October 2020. Mr Hanrahan advised that Mr Sundstrom was to undertake those blocks in the week after the Arbitration Hearing, so about mid-November 2020. He notes Dr Al Khawaja recommended these for both diagnostic and therapeutic reasons. Mr Hanrahan submitted that Mr Sundstrom has had such blocks three times in the past and he has only every had temporary relief from such injections.

57. Mr Hanrahan recounted the treatment undertaken by Mr Sundstrom and the details of his symptoms as noted in his statement, which I have summarised above. He submits that looking at the radiology historically one can see how unstable Mr Sundstrom's back has been as a result of the injury. He submits it is fairly clear that the condition affects multiple levels but most seriously at L4/5 and L5/S1.

58. In relation to Dr Casikar, Mr Hanrahan observed that at the time of the report Mr Sundstrom was helping his wife with the shopping and doing the best he could to assist her. He submits that Mr Sundstrom wants to have the recommended surgery to alleviate his pain and to be able to increase his activities of daily living, and he hopes his depression would be lifted.

59. Mr Hanrahan drew attention to the medication consumption of Mr Sundstrom as he is taking Panadeine Forte, Lyrica and Endone before bed. Mr Hanrahan submits that if surgery is not undertaken the alternative of keeping to this drug regime is not desirable and is a reason why the proposed surgery should be found to be reasonably necessary.

60. Mr Hanrahan referred to Dr Darwish's report, wherein the doctor states that Mr Sundstrom has tried all forms of conservative treatment including injections, physiotherapy, pain management and decompression. He acknowledged that Dr Darwish did agree with the recommendation to undertake a lumbar fusion, but only via a posterior approach and not also anteriorly.

61. In relation to Dr Al Khawaja's opinion, Mr Hanrahan calls it refreshingly frank because the doctor in detail outlines the prospects and risks of the surgery and says he cannot guarantee it will work. Reference is made to the doctor's letter to the insurer in which he explains that Mr Sundstrom has tried every type of conservative treatment and he is getting worse.

62. Mr Hanrahan was critical of Dr Casikar's opinion when the doctor uses the phrase that the surgery will not make a "spectacular difference". He submits that Dr Al Khawaja is not saying that will be the case, that Dr Al Khawaja is trying to relieve Mr Sundstrom's pain.
Mr Hanrahan argues even if the proposed surgery makes a mild improvement such that there can be a reduction of narcotic medication would be of benefit to Mr Sundstrom.

63. He notes Dr Casikar consulted with Mr Sundstrom via video. He submits that Dr Casikar limits his view to the L4/5 segment only and he has not considered the L5/S1.

64. Mr Hanrahan refers to some handwritten notes that appear in Dr Al Khawaja's records and says he assumes he is the author. However, this is not certain as they could be notes of Mr Sundstrom. In any event they refer to pain levels which were higher than that recorded by Dr Casikar and Mr Hanrahan noted the reference to losing strength in his left leg was a symptom of weakness which Dr Casikar could not observe on the video conference. He also submits that Dr Casikar takes into account that Mr Sundstrom has retired from the workforce and so it is not worth giving him surgery. It is submitted that this is an irrelevant consideration. Mr Hanrahan drew attention to Dr Al Khawaja's criticism of Dr Casikar's lack of expertise in spinal surgery.

65. Reference was made to the factors set out at [88] in *Diab* and Mr Hanrahan submitted the availability of alternate treatment has been addressed by Dr Al Khawaja as all conservative treatments have been tried. In terms of effectiveness, it was submitted that the alternative treatments have not proved to be effective. It was submitted the cost of the proposed surgery is not unusual. It was also submitted that the treatment is appropriate as it has been recommended by a specialised spinal surgeon. It was submitted a finding should be made that the surgery is reasonably necessary to improve Mr Sundstrom's pain and activities of daily living.

66. Mr Perry submitted that applying *Diab* and the factors identified by Roche DP at [88] the outcome should be adverse to Mr Sundstrom. He argues that the appropriateness of the proposed surgery at the moment is absent. He also argues that Mr Hanrahan when referring to the treatment as common treatment cannot be accepted because the proposed surgery is 360º and involves from L3 to S1. He argues that Dr Darwish is concerned about the proposed surgery. These factors he says are relevant to appropriateness and cost. In terms of effectiveness of the proposed treatment Mr Perry relies on Dr Al Khawaja. In terms of acceptance by medical experts about that the treatment is appropriate and likely to be effective, Mr Perry says there are three experts in this case and only Dr Al Khawaja proposes the surgery.

67. Mr Perry submitted Dr Al Khawaja wishes to proceed with facet blocks on 8 July 2020. He says four out of the five points referred to in *Diab* are adverse to Mr Sundstrom and so he has not established the surgery is reasonably necessary.

68. Mr Perry submits that even though Dr Al Khawaja on 13 February 2020 recommended the anterior and posterior fusion, he then raises significant doubts about the appropriateness because he refers to the surgery being complex, and he cannot guarantee it will work. Mr Perry also refers to the risks set out by Dr Al Khawaja including, but not limited to, paralysis, bladder, sexual and bowel dysfunction. Mr Perry submits that while it is responsible for the doctor to set out all the risks, the risks are very high and could be dreadful. He said Dr Al Khawaja does not quantify the risks in percentage terms. He also drew attention to the fact that Dr Al Khawaja advised the insurer that even if the procedure is successful there is a chance of adjacent segment disease or surgery being required to remove screws.

69. Mr Perry submits the down side of the proposed surgery is immense. He argues there are two alternatives to the proposed surgery. Firstly, Dr Darwish recommends fusion surgery but only posteriorly as this will lessen morbidity if an anterior fusion is performed as well. Secondly, Dr Al Khawaja on 8 July 2020 recommended the further facet joint blocks. It was submitted the risks with the facet joint blocks are less than the proposed surgery.

70. It was also argued that since Dr Al Khawaja made the recommendation for surgery he had obtained a further CT scan and then recommended the facet blocks. He added that the doctor then said if these blocks work they can be repeated two to three times, if they stop working then radio frequency treatment and sometimes surgery may be needed. Counsel emphasised the word "sometimes". Mr Perry submits that this is a different recommendation to what Dr Al Khawaja made in February 2020. He argues that the only reason advanced by Mr Hanrahan why this should not be viewed as alternate treatment is because in the past they have not worked. He submitted this is speculation. He also criticised Mr Hanrahan's mention of post laminectomy syndrome as there is no medical evidence to that effect.

71. In relation to Dr Casikar, it was submitted that while Dr Al Khawaja said he disagreed with Dr Casikar's opinion on the grounds of his expertise in relation to this type of surgery, Mr Perry submits that Dr Al Khawaja did not address what Dr Casikar stated. Counsel noted that Dr Casikar referred to evidenced based studies that multi-segmental fusion has a very poor outcome. He says Dr Al Khawaja does not address this.

72. He submitted that it is completely inappropriate for a finding to be made now that a posterior and anterior fusion from L3 to S1 is reasonably necessary within the meaning of section 60 as explained in *Diab*. In response to my question, Mr Perry agreed that if no order was made now in favour of Mr Sundstrom he would not be precluded from making a further application for surgery, if Dr Al Khawaja then recommended it, and based upon further evidence being placed before the Commission.

73. Mr Hanrahan in reply submitted that the Commission needs to look at the overall clinical picture and the treatment that has already occurred. It was suggested the longer a person waits for surgery it is less likely to be successful. It was submitted that it is clear from the tenor of Dr Al Khawaja's reports that he is not going to rush into surgery, and he has expressed the view that some patients need such surgery and Mr Sundstrom falls into this category. He submitted that if the Commission finds the proposed surgery is reasonably necessary there will be steps approaching that procedure and the doctor would not necessarily undertake the surgery unless it became necessary in his clinical view. It was submitted it is a matter between a patient and his doctor and it is not for the insurer to interfere with the selection of treatment.

Discussion

74. Because of the evidence in this matter, this case has not been straightforward to determine. It would have been helpful had a report been obtained from Dr Al Khawaja to comment on Dr Darwish's opinion that an anterior approach is not recommended. However, I find it is significant that Dr Darwish in mid-August 2020 did agree that a fusion from L3 to S1 was reasonable treatment as Mr Sundstrom has tried all forms of conservative treatment.

75. Dr Darwish did not recommend, as an alternative to surgery, any further conservative treatment. The fact that two practising neurosurgeons, specialising in spinal surgery, have supported lumbar fusion for Mr Sundstrom from L3 to S1 suggests to me that the contrary opinion from Dr Casikar should not be afforded weight.

76. The opinion of Dr Casikar has a number of features that are troublesome. He states that Mr Sundstrom has recovered from the workplace injury and his present symptoms are due to degenerative disease. The respondent has not taken this approach when running the case. Mr Perry accepts the symptoms suffered by Mr Sundstrom are work related. Another aspect of his opinion of concern is the finding that the surgery proposed by Dr Al Khawaja is unlikely to make any "spectacular difference" to the symptoms. This is not the test. As Mr Hanrahan submitted the aim of the surgery is to provide pain relief and an improvement in Mr Sundstrom's activities of daily living. Dr Al Khawaja has never said the surgery would provide a spectacular difference. Furthermore, even though Dr Casikar said such multilevel fusion has poor outcome for pain relief and lifestyle he does not cite the articles to which he refers.

77. All Dr Casikar suggests as an alternative is regular home based exercises and simple medications for pain. Yet Dr Casikar says he is not sure if Lyrica is still required. Dr Darwish in August 2020, three months after Dr Casikar's report, noted Mr Sundstrom was taking Panadeine Forte, Lyrica and Endone at night. Dr Darwish did not question this regime of medication. So Dr Casikar opinion seems to be an outlier view.

78. Of further concern is that Dr Casikar says following the surgery his sciatic pain has significantly reduced. However, Dr Darwish observed that Mr Sundstrom walked with a limp and complained of lower back pain radiating to the left leg associated with paraesthesia below the left knee. On his examination Dr Darwish found that straight leg raising test was 80 degrees on the left side with positive nerve stretch test and Mr Sundstrom had decreased sensation over the lateral and medial aspects of the left leg in the distribution of the left L4 and L5 dermatomes. Dr Casikar did not do a physical examination as his consultation was via video. Therefore, I find caution needs to be exercised when considering his findings. Given Dr Darwish's findings on examination, I am not convinced that Dr Casikar has based his opinion on a correct understanding of Mr Sundstrom's ongoing effects of the work-related injury.

79. Finally, another area of concern regarding Dr Casikar's opinion is that he ends his report with the following:

> "I have requested Mr Sundstrom lo bring his x-rays to my office. I will have a look at them and get back to you for further clarification of his MRI images, both preoperative and postoperative."

There is no further report from Dr Casikar so I cannot be confident that the views he has expressed would be maintained had he viewed this radiology, notwithstanding that he had available various radiological reports.

80. Accordingly, I find that I do not place weight on Dr Casikar's opinions and prefer the evidence from Dr Al Khawaja and Dr Darwish.

81. Both Dr Al Khawaja and Dr Darwish have expressed the view that surgery from L3 to S1 is appropriate. The only difference of opinion is whether the fusion should be done anteriorly in addition to posteriorly. While I consider it would have been helpful to have Dr Al Khawaja comment on Dr Darwish's opinion, I consider that the fact that Dr Al Khawaja has seen Mr Sundstrom on multiple occasions over three years, and has operated previously, places him in a superior position than Dr Darwish to decide on the exact method of the surgery to be undertaken, as Dr Darwish only saw Mr Sundstrom the once. So, to the extent there is difference I prefer the opinion of Dr Al Khawaja.

82. The parties have each submitted about the factors cited in *Diab* from Judge Burke's decision in *Rose,* being:

> "(a) the appropriateness of the particular treatment;
> (b) the availability of alternative treatment, and its potential effectiveness;
> (c) the cost of the treatment;
> (d) the actual or potential effectiveness of the treatment, and
> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective."

83. The appropriateness of the treatment, I find, is supported by Dr Al Khawaja. Notwithstanding that he has set out the risks of the proposed surgery in detail, he nonetheless recommended the surgery. He is an experienced spinal surgeon, well acquainted with Mr Sundstrom's condition, and considers the type of surgery to be appropriate.

84. Mr Sundstrom has tried exercise, physiotherapy, hydrotherapy, block injections and pain medication. Dr Darwish supports Dr Al Khawaja's opinion that all conservative treatment has been tried. While the respondent has submitted that the facet blocks are an alternate treatment, I consider it is relevant to consider that Mr Sundstrom in the past has had only short term relief from such injections and he has had multiple sessions of such injections. Therefore, the potential effectiveness of such treatment can be viewed as limited.

85. The cost of the surgery is a factor to consider, it certainly will be more than the block injections, but is not so expensive to be a significant concern.

86. The effectiveness of the proposed surgery is a difficult issue. Dr Al Khawaja acknowledges that he cannot guarantee the outcome and he has an extensive list of the risks, and many of them, as the respondent submitted, are dreadful. However, in light of such risks I consider a specialist spinal surgeon would not recommend such surgery if he considered the potential effectiveness outweighed the risks and he needs to explain all possible risks to a patient.

87. Taking into the matters in *Diab* discussed above, I find that the proposed surgery is reasonably necessary treatment.

88. However, I have considered the respondent's submission that I should decline to make an order on the present evidence and Mr Sundstrom could bring further proceedings with additional evidence once the outcome of the injections are known. However, the difficulty with that approach is the delay. It took the insurer from 8 July 2020 to end of October 2020 to approve the facet blocks. It is now three years since the injury. Mr Sundstrom's statutory declaration was sworn on 28 August 2020 and he speaks about the pain radiating on both sides and to his restrictions in his daily living. Given the length of time that Mr Sundstrom has been trying conservative treatment, I consider it is at a point now where a finding should be made that the proposed surgery is reasonably necessary. I also find it is unrealistic to think that Mr Sundstrom and Dr Al Khawaja would proceed with the surgery in the event that the block injections, unlike in the past, this time were effective. Just because the Commission makes a finding that the proposed surgery is reasonably necessary and orders the respondent to pay for the same, does not mean it must go ahead if circumstances change. Mr Hanrahan's submissions made reference to such matters. In *Diab* Roche DP stated the criteria he cited from *Rose* were not an exhaustive list of relevant matters. I find it is relevant to also consider the above factors.

89. Accordingly, I find that the surgery was reasonably necessary treatment as a result of the injury on 6 November 2017.

90. I order that the respondent is to pay for the lumbar surgery pursuant to the applicable workers compensation gazetted rates.