WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-4654/19**
Appellant:	**Bruce James Hutchison**
Respondent:	**Wyong Race Club**
Date of Decision:	**15 April 2020**
Citation:	**[2020] NSWWCCMA 73**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr Richard Crane**
Approved Medical Specialist:	**Dr Gregory McGroder**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 10 February 2020, Bruce James Hutchison lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Philip Truskett, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 8 January 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 that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because we consider that we have sufficient evidence before us to enable us to determine the appeal.

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.

SUBMISSIONS

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

10. In summary, the appellant submits that the AMS erred in his assessment of all body parts referred, and in particular failed to draw to the attention of the appellant evidence of his apparent recovery from the injuries.

11. In reply, the respondent submits that no errors were made.

FINDINGS AND REASONS

12. 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.

13. 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.

14. The appellant was referred to the AMS for assessment of whole person impairment (WPI) in respect of the Cervical Spine, Lumbar Spine, Right Upper Extremity (right shoulder) and Digestive System resulting from an injury on 8 June 2011.

15. The AMS obtained the following history:

> "At the time Mr Hutchison was employed by Wyong Racing as a groundsman and barrier attendant. He worked for this organisation in a full-time casual capacity from 2009 to 2012.
>
> Mr Hutchison described an injury which occurred on 30 June [sic] 2011… He was helping horses into the barriers…This restive horse crushed him against the gate. He was wearing a helmet and protective vest. He was not knocked out…
>
> The following morning he woke with pain in his left side of neck and back of neck and head. There was also pain in his right shoulder and lower back.
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> Mr Hutchison attended his Local Medical Officer, Dr Mah of Wallsend, the following day… Imaging was performed. He was provided with analgesics.

> Approximately 1 to 2 months later, he was referred to Dr Schwarzer (Consultant Physician, Rheumatologist and Pain Physician)…Apparently, Dr Schwarzer subsequently did injections into Mr Hutchison's back and radiofrequency ablation to his neck with some relief.
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> In relation to his right shoulder, Mr Hutchison attended Dr Kemp of Broadmeadow, who also did injections into his right shoulder under ultrasound control…
>
> In relation to work, Mr Hutchison was off work for 2 months. He said he attempted to return to light duties on two occasions, performing office work, but was unable to continue."

16. After documenting the appellant's present treatment, the AMS then set out his present symptoms with respect to the neck, the lower back, the right shoulder and the gastrointestinal tract.

17. As regards social activities and ADL's, the AMS said:

> "Mr Hutchison has been married since 1985. He and his wife have no children. He lives in a house which is rented on 40 acres. They have dogs, one horse and used to have sheep.
>
> He describes himself as being severely incapacitated. He always uses a walking stick in his right hand and has done so for more than 18 months. He is unable to run or jog. He could walk for approximately 600m. He is able to climb stairs; one step at a time. He has a flight of stairs at home. The bedrooms are upstairs. He can sit for 30 to 60 minutes. He can stand for 2 to 10 minutes. He is able to drive a car for 60 minutes. He is unable to do housework. He can use a ride-on mower for 15 to 30 minutes. He can water the garden. He is able to cook. He can go shopping. He does not socialise. He finds it difficult to wash himself and is assisted by his wife but does not use a chair in the shower. He said the shower is too small to do this.
>
> He used to play golf, enjoyed fishing and sailing, and horse racing, but is no longer able to do these activities. He occasionally goes to dog shows with his wife when her dogs are being shown."

18. Findings on physical examination were reported as follows:

> "Mr Hutchison was a man who appeared incredibly distressed throughout the interview with much groaning and puffing.
>
> He walked with a waddling wide-based gait in a very slow fashion with a limp involving his right leg. This was in considerable contrast as I by chance, walked behind him in the street when he walked to attending the interview. He appeared to walk quite normally. I asked him why this was so. He had no explanation. He also limped on his right leg leaning on a walking stick in his right hand. This is his painful shoulder that would exacerbate his shoulder pain. He could easily walk with the stick using his pain free left upper limb. This would produce a preferable walking cadence. Patients are taught to use a stick in the hand opposite to support the impaired lower limb. This is almost instinctive. I asked why he did not use his pain free left upper limb to hold his walking stick. He had no explanation.
>
> He climbed on and off the examination couch with the aid of his walking stick and sat incredibly awkwardly in a most uncomfortable fashion on the corner of the bench. I would describe this behaviour as marked illness behaviour…

All movements during examination were extremely laborious and appeared to be very uncomfortable.

On examining his neck, there was initial guarding, which was voluntary, which released with distraction. There was marked limitation of neck movement but no dysmetria. Neck flexion and extension was one quarter normal, lateral flexion to the left and right was one quarter normal, and rotation to the left and right was one quarter normal. Each movement was done extremely slowly.

Mr Hutchison had an intermittent tremor of his right upper limb and right lower limb. There was however no cogwheeling but appeared to have increased tone. This is most unusual and also add odd choice to carry a walking stick. Parkinson's disease can start on one side of the body, but this tremor was not typically Parkinsonian.

On examining sensation at the right upper limb, there was increased sensation at the top of the right shoulder to the deltoid region, which extended onto the side of his neck. This was not of a radicular distribution. Reflexes could not be elicited on his right arm due to his tremor. He appeared to have reduced grip strength on the right as compared to the left.

There was no wasting of the muscles of the upper limbs. Both arms measured 40cm in circumference, 10cm above the olecranon and both forearms measured 31cm at their widest point.

On examining his back, there was no kyphosis or scoliosis. There was no loss of lumbar lordosis. There was no paravertebral muscle guarding.

Straight leg raising was possible to 30° in the lying position. This led to buttock pain. However, in the sitting position, both legs could be elevated to 90° without complaint.

Sensation was normal on both lower limbs. When attempting to test reflexes on the right, this was overcome by the tremor. Reflexes on the left, including knee jerk, hamstring jerk and ankle jerk, were all normal.

There was no wasting of the muscles of the lower limbs. Both thighs measured 63cm in circumference, 10cm above the patella, and both calves measured 46cm at their widest point.

There was minimal back movement. There was however no dysmetria. Back flexion and extension was one-eight normal, lateral flexion to the left and right was one-eighth normal, and rotation to the left and right was one quarter normal.

Mr Hutchison said he could not walk on his toes or his heels. He was not requested to do so.

On examining his abdomen, his abdomen was soft. There were no palpable masses. There was no organomegaly. There was no ascites. There was no evidence of jaundice or anaemia. There were no abdominal wall hernias.

On examining both shoulders, there was reduction in right shoulder movement... There was no impingement signs. There was no wasting of the muscles of the shoulder girdles."

19. The AMS then set out details of the radiological material he had, all performed in 2011.

20. As regards consistency of presentation, the AMS said:

> "As noted, there was considerable inconsistency when observing Mr Hutchison's gait outside the environment of the examination room. He was asked why this was so. He had no explanation. There was also a strange choice of use of a walking stick in his painful right upper limb when a pain free left upper limb was available.
>
> He had a sensory loss over his right side of chin, neck and right shoulder that was not anatomical.
>
> There was also inconsistency in his straight leg raising. He could only manage 30° when lying flat, but 90° when sitting. There seemed to be no discomfort.
>
> He exhibited an inconsistent intermittent tremor of his right upper limb and right lower limb, which was not characteristic.
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> His movement and mobility seemed incredibly restrained without any convincing evidence of radiological abnormality."

21. When asked: "Indicate whether there has been any further injury subsequent to the subject work injury. If this injury has caused any additional impairment this should not be included with the assessment of impairment due to the subject work injury" the AMS said:

> "As outlined in my explanation below, it is my view that the current right shoulder impairment has occurred subsequent to his injury of June 2011. The reason for this conclusion is based on documentation provided from Dr Kemp, his treating shoulder specialist. In his letter of initial assessment dated 6 September 2012, he described limitation of right shoulder movement and commented that the ultrasound assessment demonstrated that the rotator cuff was intact. He stated that 'I have no hesitation that there is evidence of significant capsulitis (frozen shoulder) in Bruce's shoulder.' From documentation provided, I agree with this diagnosis. In his subsequent letter dated 18 March 2018 [sic- 2013], he documents full recovery of right shoulder movement. This is the nature of 'frozen shoulder'. The condition does not recur. Any current limitation of right shoulder movement would therefore be unrelated to his original injury in June 2011. The current impairment should, therefore, be fully deducted."

22. The AMS assessed 0% impairment. His reasons were as follows:

> "**Cervical Spine**. Stable. Reference is made to AMA 5, Chapter 15, Table 15-5, Page 392 and WorkCover Guides, 4th Edition, 1 April 2016, Chapter 4, Page 24-30, equating to 0% whole person impairment. Despite Mr Hutchison's apparent discomfort, limitation of movement is assessed as DRE Category I, with 0% whole person impairment. This is because there is no muscle guarding, no neurological signs, no significant loss of motion segment integrity and no fractures. It is also noted this CT scan of the cervical spine is entirely normal.
>
> **Lumbar Spine**. Stable. Reference is made to AMA 5, Chapter 15, Table 15-3, Page 384 and WorkCover Guides, 4th Edition, 1 April 2016, Chapter 4, Page 24-30, equating to 0% whole person impairment. A DRE Category I is assigned as even though there was limited back movement, there was no muscle guarding, no relevant neurological signs, no dsymetria and no bony injury. Plain x-ray of the lumbar spine also shows no abnormality.
>
> **Right Shoulder**. Stable. Reference is made to AMA 5, Chapter 16, Section 16.4i, Page 474, Figure 16-40, Page 476, Figure 16-43, Page 477 and Figure 16-46, Page 479, and Table 16-3, Page 439, and the WorkCover Guides, 4th Edition, 1 April 2016, Chapter 2, Page 10-12. A whole person impairment of 8% is assigned.

According to the quoted pie charts, Mr Hutchison's limitation of movement equates to 13% impairment of his right upper limb, which when Table 16-3, Page 439, is consulted equates to an 8% whole person impairment. However, as outlined in Q9. (g), this has been fully deducted as he demonstrated a full recovery of right shoulder function as described. Any impairment now must be considered a subsequent unrelated pathology.

Digestive Tract. Stable. Reference is made to NSW WorkCover Guides, Page 79, Section 6, Chapter 16, Page 78-79. In Paragraph 16-9, it directs to AMA 5, Table 6-3, Page 121, where it states Class I to be amended to read, 'there are symptoms and signs of digestive tract disease'. Reference is made to AMA 5, Page 121, Table 6-3, to be classed 0-9% whole person impairment, as both symptoms and signs of upper digestive tract disease must be present, or anatomic loss or alteration. Although there are symptoms, no anatomic loss or alteration has been demonstrated, and there are no signs. In addition, Chapter 16.9 of the WorkCover Guides, states non-steroid anti-inflammatory agents including aspirin taken for prolonged periods can cause symptoms in the upper digestive tract. In the absence of clinical signs or objective evidence of upper digestive tract disease, anatomic loss or alteration, a 0% whole person impairment is assessed. Mr Hutchison describes gastroesophageal reflux. There is no evidence of anatomic loss or signs. Therefore a 0% whole person impairment must therefore be assigned. In relation to constipation, according to third dot point, Section 16.9, Page 78, it describes constipation as a symptom not a sign and is generally reversible. A whole person impairment assessment does not apply for constipation. Therefore, Mr Hutchison's whole person impairment in relation to his gastrointestinal tract is 0%."

23. The AMS then summarised the other medical opinions as follows:

"In a medicolegal report by Dr Ghabrial dated 15 July 2015, he assessed Mr Hutchison as having a DRE Category II of the cervical spine and DRE Category II of the lumbar spine. I could not demonstrate consistent muscle guarding, dysmetria or neurological signs that would support this decision. He assessed Mr Hutchison as having a whole person impairment of his right shoulder which was not at the level which was seen today.

In a medicolegal report by Dr James Bodel dated 6 May 2019, he assessed a similar impairment to Mr Hutchison's right shoulder as described today. However, he also assigned DRE Category II to the lumbar spine and cervical spine, on the basis of asymmetry which has not been demonstrated today.

In a medicolegal report by Dr Chris Harrington dated 6 August 2019, he did demonstrate a similar reduction in right shoulder movement but did describe this as being unrelated. He did not give a reason why this was unrelated.

In Dr Kemp's report on 18 March 2013, his shoulder specialist, he did state that Mr Hutchison's frozen right shoulder had resolved, and he demonstrated a full range of movement with good strength. Dr Kemp had made a diagnosis of 'frozen shoulder' which could well have been the consequence of this injury. The natural history of 'frozen shoulder' is that it at first becomes painful, then stiff and painful and then often resolves. It does not recur. It is quite conceivable that Mr Hutchison sustained a frozen shoulder which resolved. The only imaging provided of his Right shoulder is an Ultrasound dated 13 December 2011which shows only minor changes and could be consistent with 'frozen shoulder aka capsulitis'. If shoulder movement has deteriorated from that time it is most unlikely to be due to the initial shoulder injury of June 2011. He was not seen by Dr Bodel until 27 April 2015, some 2 years after Dr Kemp had demonstrated complete shoulder recovery. I must presume something must have happened to his right shoulder in these intervening years.

> In a medicolegal report by Professor Terry Bolin dated 3 July 2018, he assessed Mr Hutchison as a 7% whole person impairment for upper digestive tract disease on the basis of symptoms provided. Professor Bolin, however, did not make reference to the WorkCover Guides, which demonstrated there needed to be symptoms and signs of upper digestive tract disease. This assessment therefore cannot be supported."

24. The appellant's grounds of appeal are as follows:

    (a) As regards the right upper extremity (shoulder) the AMS erred by applying a complete deduction of the range of movement score, when he did not, at any time, bring the applicant's attention to the alleged "recovery" of his range of movement by March 2013 and when he did not, at any time, have evidence before him that the "frozen shoulder" had "fully recovered".

    (b) Further, the AMS erred by failing to bring to the appellant's attention to, or identify any cause, that would explain the presence of abnormal ROM, since March 2013, when he found [at 8g and page 10] the ROM finding "must now be considered a subsequent unrelated pathology".

    (c) As regards the cervical and lumbar spines, the AMS erred when he did not, at any time, bring the applicant's attention to the alleged "recovery" of his "asymmetric" range of movement in the period from the examinations of Dr Ghabrial on 15 July 2015 and Dr Bodel on 6 May 2019.

    (d) The AMS erred when he applied a finding of an absence of "dysmetria", an irrelevant enquiry for the purpose of the assessment.

25. Dealing firstly with the right shoulder, the appellant submits that "the evidence on which [the AMS] relied appears to be the report of Dr Kemp… Dr Truskett's finding of 'full recovery of range of movement' at that time was clearly an unavailable conclusion". It is illogical and unreasonable to find the applicant had fully recovered his range of movement and/or that the current range of movement was from a 'subsequent unrelated pathology'.

26. The appellant goes on to refer to a number of authorities dealing with the correct interpretation of "incorrect criteria" and "demonstrable error" and the proper construction of s 323 of the 1998 Act.

27. The appellant then said:

> "The applicant submits the applicant was not afforded natural justice to proffer an explanation for his 'changed ROM', or 'deterioration of ROM', between March 2013 and the date of the assessment by Dr Truskett, There is no evidence that Dr Truskett brought the content of the report of Dr Kemp to his attention at any time, although Dr Truskett had the report in his possession and intended (and did in fact) rely on its content (albiet erroneously) in his opinion. In denying him this opportunity, there has been procedural unfairness and the opinion and findings relating to the right shoulder 'were manifestly deficient and did not constitute compliance with the minimum obligation' of his delegated statutory power…"

28. The appellant then makes the same submission as regards the difference between the reported findings of Dr Ghabrial on 15 July 2015 and Dr Bodel on 6 May 2019 and the date of the assessment by the AMS, adding: "There is no evidence that Dr Truskett brought the contents of the reports of Drs Ghabrial and Bodel to his attention at any time."

29. The appellant seems to have assumed that the AMS has made a deduction in respect of the right shoulder under s 323 of the Act. This is not the case.

30. The AMS was required to assess WPI that resulted from the injury on 8 June 2011 only. The AMS concluded that there was no impairment of the right shoulder from that injury. In making that assessment the AMS concluded that there must have been some other occurrence to explain the appellant's presentation on the day of his examination, given the findings by Dr Kemp in 2013.

31. Such a conclusion was open to him.

32. He did not make any deduction pursuant to s 323: he referred to his role in evaluating permanent impairment under the Guidelines at paragraph 8 (g) of the MAC.

33. In our view, there was ample evidence to permit him to make such an assessment.

34. We do agree however that the manner of explanation of his assessment in respect of the right upper extremity was not entirely clear.

35. It would perhaps have been preferable for the AMS to simply state that there was no impairment as a result of the injury in June 2011.

36. What he appears to have done is accept (to a degree) some restrictions, as did other doctors, particularly Dr Bodel. The AMS said of Dr Bodel: "he assessed a similar impairment to Mr Hutchison's right shoulder as described today." The AMS has essentially adopted his findings then made a "deduction" because "he demonstrated a full recovery of right shoulder function as described."

37. As we said, although perhaps not clearly explained, the AMS' assessment and conclusions were open to him on all the evidence.

38. The appellant's submissions really focus on an alleged failure by the AMS to bring what we may term "discrepancies" or "inconsistencies" in the evidence to the attention of the appellant.

39. That is not the task of an AMS.

40. In any event, we note that the AMS repeatedly asked the appellant about various inconsistencies, for example, the use of a cane in his right hand despite his apparent severe shoulder pain. The AMS said: "Patients are taught to use a stick in the hand opposite to support the impaired lower limb. This is almost instinctive. I asked why he did not use his pain free left upper limb to hold his walking stick. He had no explanation."

41. Similarly as regards his gait. The AMS said:

> "He walked with a waddling wide-based gait in a very slow fashion with a limp involving his right leg. This was in considerable contrast as I by chance, walked behind him in the street when he walked to attending the interview. He appeared to walk quite normally. I asked him why this was so. He had no explanation."

42. Allegations of a denial of natural justice and procedural fairness do not constitute neither the application of incorrect criteria nor a demonstrable error. The task of the Approved Medical Specialist is simply to carry out an examination and make an assessment of impairment (if any).

43. As the respondent correctly points out, "there is no requirement for an AMS to seek an explanation from the worker concerning matters which are the subject of his physical examination and assessment. Indeed, to do so would be improper…"

44. For these reasons, we cannot see any error in his assessment with respect to the right upper extremity.

45. As regards the cervical and lumbar spines, the only error identified by the appellant is that the AMS "applied a finding of an absence of 'dysmetria', an irrelevant enquiry for the purpose of the assessment."

46. This ground of appeal is misguided. "Dysmetria" and "Asymetria" are one and the same.

47. In any event, as the respondent points out, "the assessment by the AMS… was based on the absence of muscle guarding, the absence of neurological signs, the absence of any loss of motion or segment integrity and the absence of any fractures or bony injury".

48. In addition, we note that the assessment was both consistent with his examination and with the assessment of Dr Harrington.

49. For these reasons, we do not accept that the AMS erred in his assessments with respect to the cervical and lumbar spines.

50. In short, the submissions by the appellant reflect mere disagreement with the opinion and assessment by the AMS.

51. This is not a proper basis for appeal.

52. For these reasons, the Appeal Panel has determined that the MAC issued on 8 January 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*.

A Jackson

Ann Jackson
Dispute Services Officer
As delegate of the Registrar