WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1724/20**
Applicant: **Matthew Clark**
Respondent: **Secretary, Department of Transport**
Date of Determination: **25 June 2020**
Citation: **[2020] NSWWCC 210**

The Commission determines:

1. The medicinal cannabis treatment which the applicant has undergone to date is reasonably necessary.

The Commission orders:

1. The respondent is to meet the cost of the medicinal cannabis treatment incurred by the applicant to date.

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

John Isaksen
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 JOHN ISAKSEN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Matthew Clark, sustained multiple injuries in a motor accident whilst on his way home from work with the respondent, the Department of Transport, on 6 January 1988.

2. The applicant sustained fractures of the right femur, both left and right tibia and fibula, right ankle and right wrist, as well as injury to the lower back.

3. In 2019, the parties entered into a Complying Agreement whereby it was agreed that the applicant has 10% permanent impairment of the neck, 15% permanent loss of the use of the right arm at or above the elbow, 20% permanent loss of use of the right arm below the elbow, 10% permanent loss of use of the left arm below the elbow, 40% permanent loss of use of right leg at or above the knee, 10% permanent loss of use of left leg at or above the knee, 20% permanent impairment of the back, 5% severe facial disfigurement and 10% severe bodily disfigurement, as a result of the injury on 6 January 1988.

4. The respondent concedes that the applicant has over 20% permanent impairment as a result of the injury on 6 January 1988.

5. The applicant claims that the cost of the treatment of medicinal cannabis which has been provided to him since June 2018 be paid for by the respondent, and an order pursuant to section 60 (5) of the *Workers Compensation Act 1987* (the 1987 Act) for the respondent to meet the payment of ongoing medicinal cannabis treatment.

6. The respondent disputes this treatment is reasonably necessary as provided by section 60 of the 1987 Act and has issued dispute notices dated 28 August 2018 and 18 February 2019 wherein it declined liability for this treatment.

ISSUES FOR DETERMINATION

7. The parties agree that the following issue remains in dispute:

    (a) Whether medicinal cannabis treatment that has been provided to the applicant, and is proposed as further treatment for the applicant, is reasonably necessary.

PROCEDURE BEFORE THE COMMISSION

8. The parties attended a conference and hearing on 18 June 2020. 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.

9. Mr Stockley appeared for the applicant, instructed by Mr Macauley. Mr Robertson appeared for the respondent, instructed by Ms King.

10. The hearing was conducted by telephone in accordance with the protocols set out by the Commission as a result of the coronavirus pandemic.

EVIDENCE

Documentary Evidence

11. 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) Application to Admit Late Documents filed by the applicant on 29 April 2020;

    (d) Application to Admit Late Documents filed by the respondent on 8 May 2020;

    (e) Application to Admit Late Documents filed by the applicant on 4 June 2020.

Oral Evidence

12. There was no application to cross-examine the applicant or to adduce oral evidence.

FINDINGS AND REASONS

The evidence of the applicant

13. The applicant has provided statements dated 24 July 2017 and 7 June 2019.

14. In his statement dated 7 June 2019, the applicant states that he has pain in many parts of his body but especially in the right leg, right wrist and lower back. He rates the pain as routinely 8 out of 10 in severity.

15. The applicant states that he takes Oxycontin and Tramadol for pain relief but that the side effects are very excessive. He complains of feeling nauseous and ill from taking both medications. He states that he does not think the medications are relieving much of his pain.

16. The applicant states that he was taking Lyrica but stopped taking this medication because he became drowsy and confused and had suicidal thoughts.

17. The applicant states that he has previously taken Panadeine Forte and Endone, but those medications did not give him much pain relief. He states that he occasionally takes Endep for pain relief.

18. The applicant states that he used to use alcohol for pain relief but rarely drinks alcohol now.

19. The applicant states that he has previously self-medicated with cannabis and found it extremely effective in reducing his chronic pain.

20. The applicant states that since the middle of 2018 he has been prescribed medicinal cannabis by Dr Towpik and has paid for that treatment himself. He states that his general practitioner, Dr Barrell, referred to him to Dr Towpik, who the applicant understands is a specialist in medicinal cannabis. The applicant states:

> "I have found it by far to provide the best method of pain relief. I am able to function better during the day and the activities of my day to day living and much easier to perform. I don't feel like a zombie. My sleep is much better."

21. The applicant states that the medicinal cannabis acts within 10 minutes, whereas Tramadol takes two and a half hours to work.

22. The earlier statement of the applicant dated 24 July 2017 provides details of problems that the applicant has had over the years since the injuries he sustained on 6 January 1988. He states that about a week before that statement he took 30mg of Oxycontin and "it was good." He states: "This is the best I have been for 10 years and I do not want to change anything yet."

The medical evidence

23. Dr Towpik has provided a report dated 12 September 2019. The first three and a half pages of that report seems to be a standard treatise on the benefits of medicinal cannabis. Dr Towpik then refers specifically to her treatment of the applicant.

24. Dr Towpik writes that on the first presentation in June 2018, the applicant presented with a pain level which the applicant rated at around 7-8 on average. Dr Towpik writes the applicant had trialled multiple pharmacological agents without significant improvement and side effects. She writes that all opiates caused drowsiness, constipation and were ineffective. Dr Towpik then writes:

> "I determined that patient was eligible for medicinal cannabis because he wasn't responding to conventional pharmaceutical agents.
>
> He was prescribed CannTrust, cannabis oil product containing THC 12.5 mg/ml and CBD 12.5 mg/ ml. This formulation became unavailable in April this year and I applied for a combination of cannabis oil called LGP Classic 10:10 (THC 10mg/ml and CBD 10 mg/ml) and dry flower Bediol (THC 6.3% CBD 8%) for vaping to address the breakthrough pain.
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> This patient responded very well to this treatment, reporting improved pain, sleep, mood and overall quality of life."

25. Copies of receipts which are in the ARD and the Application to Admit Late Documents filed by the applicant on 4 June 2020 indicate that medicinal cannabis was prescribed by Dr Towpik until April 2020. Since then Dr Holtzman has taken over the applicant's medicinal cannabis treatment. Dr Holtzman has provided a report dated 15 May 2020 which mostly copies what Dr Towpik has previously written in regard to the applicant but adds:

> "He is now taking LGP 10:10 Cannabis oil 0.2ml mane, 0.3ml at 2 pm, 0.4 ml at 6 pm, 0.3 ml at 9 pm and 0.3 ml at midnight PRN and vaping Bediol PRN up to 0.5g daily.
>
> This regimen is controlling his pain quite well and there was no need to increase his dose since July 2019."

26. There are reports in evidence from Dr Ho, pain and rehabilitation specialist, dated 19 November 2019 and 1 June 2020.

27. The report dated 19 November 2019 is addressed to Dr Barrell. Dr Ho records that the applicant takes Panadeine Forte when required, one to two Endone three days per week, Oxycontin in the morning and night, and Endep at night. Dr Ho writes that the applicant has significant refractory pain despite this treatment. He records that the applicant reports a 30% improvement of pain, a 30-50% improvement in function and sleep, and 50% reduction in opiate medication, since undergoing the medicinal cannabis treatment.

28. Dr Ho concludes:

> "He reports no side-effects from cannabis oil and there is no aberrant behaviour. In my opinion he has had a successful trial of medicinal cannabis given the medication reduction, pain reduction, functional improvement and no side-effects.
>
> In my opinion ongoing cannabis treatment for his chronic pain condition as above is reasonably necessary with ongoing mental core supervision."

29. The second report from Dr Ho dated 1 June 2020 is addressed to the applicant's solicitors. Dr Ho opines that a trial of medicinal cannabis for the applicant is appropriate given his neuropathic pain has been refractory to more conservative medication treatment. Dr Ho suggests a psychologist's clearance to rule out any risk factors. He notes that a trial must be on a case by case basis and based upon a personalised medicine principle.

30. Dr Ho writes that the potential harm related to medicinal cannabis is significantly lower compared to opioid medication and that if clinically meaningful significant reduction of opioid medication can be achieved with the trial, then the use of medicinal cannabis should be supported.

31. Dr Ho does suggest an alternative is for a further intensive pain management program to improve pain coping skills, but does conclude:

> "In my opinion, the trial of cannabis oil is reasonably necessary, and ongoing trial is hinging on the demonstration of safety and efficacy. In my opinion, Cannabis oil should only be the adjunct to pain self-management strategy, with a goal of pain coping and not pain cure."

32. There is a short report from Darren Wilson, psychologist, to Dr Datta at Blackheath, dated 23 August 2018. Mr Wilson refers to the applicant completing 16 approved treatment sessions and writes:

> "During treatment, Mr Clark was taught strategies to increase his capacity to cope with pain management, physical pacing and injury adjustment via controlled breathing, imagery and down regulation. After completing the 16 treatment sessions, Mr Clark has successfully applied the above strategies in conjunction with his prescribed Marijuana oil and intermittent pain medication support's."

33. The applicant was examined by A/Prof Molloy, consultant anaesthetist and pain management specialist, at the request of the respondent on 19 December 2019, and has provided a report of the same date.

34. A/Prof Molloy records levels of medicinal cannabis intake which are generally consistent with that recorded by Dr Holtzman. He records that if the applicant takes any more cannabis that it impairs him. A/Prof Molloy records the applicant taking Tramadol three times per day, Oxycontin up to five times per week, Endone up to three times per week, and Codapane Forte at night. He does record that the applicant has reduced his intake of Oxycontin since he started on the medicinal cannabis.

35. A/Prof Molloy records that the applicant now has up to four alcoholic drinks for four to five nights of the week and 40 cigarettes each day.

36. A/Prof Molloy records that the applicant stopped smoking cannabis in 2004 but started again in 2019 because of PTSD, nightmares and to help with his pain.

37. A/Prof Molloy concludes that the use of medicinal cannabis in the applicant's case is complex. He writes:

> "The concern here is that he takes up to four different narcotics Tramadol, Endone, OxyContin and Codapane Forte in addition to cannabis and occasional Endep and regular alcohol."

38. A/Prof Molloy recommends an intensive cognitive behavioural pain management program. He opines that the applicant remains distressed and disabled while on this current regime of narcotics and cannabis.

39. Mayez Hijazi, pharmacist, has provided a report at the request of the respondent dated 31 December 2019. Mr Hijazi writes that he had a conversation with Dr Barrell and he lists details of medication that he is told are taken by the applicant. Those details are largely consistent with the details recorded by Dr Ho, except that Mr Hijazi records the applicant taking Panadeine Forte up to four times daily, whereas Dr Ho records that this drug is only taken when required by the applicant.

40. Mr Hijazi also records that the applicant ceased using medicinal cannabis in October 2019 and that his use of narcotic analgesics has significantly increased.

41. Mr Hijazi writes that the applicant's use of Panadeine Forte, Endep and Endone is within the recommended range. He writes that the daily dose of Oxycontin is a high dose. He writes that the use of Tramal is the maximum recommended daily dosage, but it is not within the recommended range for the continual high dosage which the applicant has been taking. Mr Hijazi also writes that "the current doses of opioid agents are not within the normal recommended range for chronic non-cancer pain."

42. Mr Hijazi opines that the respondent should not meet the cost of any further medicinal cannabis treatment by the applicant because there are no clear pathways in terms of duration for this treatment and the applicant has had a past history of illicit use of cannabis. He also opines that the demand for high dose opioids and illicit substance abuse is more the result of established dependency rather than for pain relief.

43. Mr Robertson for the respondent referred to medical evidence which pre-dates this particular dispute as being pertinent to what I must determine.

44. The applicant attended Dr Sundaraj, pain consultant, on 19 November 2004. Dr Sundaraj records a history of cannabis and opioid dependency and suspects the applicant is continuing cannabis consumption. He writes that he has concerns about the applicant's long term cannabis use.

45. In a further report dated 26 May 2005, Dr Sundaraj writes that on a couple of occasions the applicant has been intoxicated with cannabis when he has attended Nepean Pain Management. He writes that the applicant does not consider himself addicted to cannabis and that the applicant could stop his use at any time. Dr Sundaraj opines that this is a rationalisation of a dependent personality.

46. Dr Sundaraj writes that he cannot be of any further assistance to the applicant because: "Chronic pain does not seem to be a major issue rather the dependency factor."

47. Paul Wynn, psychologist from Nepean Pain Management, in a report dated 10 December 2004, records that the applicant uses prescribed medication, alcohol and cannabis as primary pain management strategies.

48. Mr Wynn records the applicant having ceased using cannabis but then started using cannabis every second day, although he intends to cease the use completely.

49. In a report dated 28 April 2005, Dr Moss, occupational health practitioner, records that the applicant has relapsed to cannabis smoking and that he said: "I really like it." Dr Moss also records the applicant saying: "I have come to realise I cannot live without cannabis."

50. Dr Samuell, clinical psychiatrist, records in January 2006 that in addition to opioid medication, the applicant consumes three glasses of Jack Daniels each day, smokes two or three kinds of marijuana, and smokes two packets of cigarettes each day.

51. Dr Samuell opines:

> "Mr Clark's pain management would certainly be improved if he was detoxified both from narcotic analgesics and from his cannabis, alcohol and cigarette use. He presented a willingness to do this."

52. Dr Kenna, consultant in musculoskeletal pain management, writes in a report dated 23 September 2014 that he understood the applicant was still taking cannabis.

53. Dr New, orthopaedic surgeon, makes reference in a report dated 29 November 2017 to the applicant seeking pain relief through alcohol and marijuana, as well as opioids.

Determination

54. The decision of Burke CCJ in *Rose v Health Commission (NSW)* [1986] NSWCC 2; (1986) 2 NSWCCR 32 (*Rose*) remains as a textbook explanation for the purpose and application of what was then section 10 of the 1926 Act, now section 60 of the 1987 Act:

> "1. *Prima facie*, if the treatment falls within the definition of medical treatment in section 10(2), it is relevant medical treatment for the purposes of this Act. Broadly then, treatment that is given by, or at the direction of, a medical practitioner or consists of the supply of medicines or medical supplies is such treatment.
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> 2. However, although falling within that ambit and thereby presumed reasonable, that presumption is rebuttable (and there would be an evidentiary onus on the parties seeking to do so). If it be shown that the particular treatment afforded is not appropriate, is not competent to alleviate the effects of injury, then it is not relevant treatment for the purposes of the Act.
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> 3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.
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> 4. It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgment and good sense, that it is so. That involves the Court in deciding, on the facts as it finds them, that the particular treatment is essential to, should be afforded to, and should not be forborne by, the worker.

5. In so deciding, the Court will have regard to medical opinion as to the relevance and appropriateness of the particular treatment, any available alternative treatment, the cost factor, the actual or potential effectiveness of the treatment and its place in the usual medical armoury of treatments for the particular condition."

55. Mr Robertson submits that the respondent does not dispute that there can be a use for medicinal cannabis in pain relief, but that it is not appropriate in this particular dispute because those doctors who have treated the applicant have not given due consideration to the applicant's past history of cannabis abuse.

56. For over 30 years now, the applicant has been coping with the effects of some serious injuries, especially to his right leg and lower back. In November 2019, Dr Ho identified the main concerns of the applicant's pain being chronic neuropathic right leg pain and chronic nociplastic lower back pain.

57. Dr Ho also identified chronic nociplastic left shoulder pain secondary to a left clavicle and scapula fracture, although I could locate those particular injuries in earlier medical evidence. However, both Dr New in November 2017 and Dr Pillemer in February 2019 recorded bilateral shoulder pain due to the prolonged use of crutches.

58. Dr Pillemer recorded the applicant's symptoms could go as high as 10/10 but that if the applicant is resting and taking tablets then he can go for up to 20 minutes feeling reasonably comfortable.

59. In my view, the applicant is entitled to have the respondent meet the costs of such reasonable treatment by way of pain relief which alleviates the consequences of his injury. The issue is whether that can include the medicinal cannabis treatment which the applicant has undertaken since June 2018.

60. The benefits to the applicant of the provision of medicinal cannabis is supported by those general practitioners who have prescribed this treatment and who have continued to review the applicant. Dr Towpik recorded that the applicant reported improved pain, sleep and overall quality of life. In May of this year, Dr Holtzman recorded that the treatment was controlling the applicant's pain quite well.

61. Although Dr Towpik is clearly an advocate for this form of pain relief, there is nothing to cause me to doubt the observations recorded by Dr Towpik and Dr Holtzman. Those doctors have a crucial role in deciding if the medicinal cannabis treatment is providing the benefit of pain relief to the applicant.

62. That the medicinal cannabis prescribed to the applicant is a reasonable form of pain relief is supported by Dr Ho. It would seem that Dr Ho has only seen the applicant on the one occasion in November 2019. I draw this conclusion from the referral from the Ochre Medical Centre dated 23 September 2019. However, Dr Ho records details of other medication which the applicant continues to take, in addition to the medicinal cannabis he consumes, and concludes that ongoing cannabis treatment for the applicant's chronic pain condition is reasonably necessary.

63. There are some concerns in the opinion expressed by Dr Ho which are identified by Mr Robertson for the respondent. Dr Ho does not refer to the applicant's prior cannabis abuse and dependence, when forming his opinion.

64. The medical evidence certainly reveals that in the past the applicant has abused, and perhaps been addicted to, cannabis. However, those records date back to a period between 2004 and 2006. There is no recent medical evidence of this.

65. In 2014 Dr Kenna records that he understood the applicant was still taking cannabis but provides no more details. There is a passing reference made by Dr New in 2017 to the applicant seeking pain relief through alcohol and marijuana but no other details provided. A/Prof Molloy records the applicant starting to use cannabis again in 2019 but does not indicate whether it has led to dependence, abuse or addiction.

66. I do not consider the opinion by Dr Ho is compromised by him not being made aware of past cannabis abuse when there is no concrete evidence that this occurred since 2006.

67. Dr Ho suggests a psychologist's clearance to rule out any risk factors. There is the report from Mr Wilson, psychologist, in August 2018 which records that the applicant had completed 16 sessions wherein he was taught strategies for pain management and that the applicant had successfully applied those strategies in conjunction with marijuana oil use.

68. The report from Mr Wilson is not detailed and is provided only a few months after the applicant commenced to use medicinal cannabis, but it does confirm that the applicant has undergone psychological treatment in anticipation of undertaking cannabis treatment, and Mr Wilson is satisfied with the applicant's suitability for this treatment. In my view, this evidence has met the concerns expressed by Dr Ho of the need for psychological oversight of the applicant.

69. Dr Ho refers to the applicant's cannabis treatment as being a trial. Dr Ho does not record when that trial commenced but the treatment provided by Dr Towpik had been in place for 17 months when the applicant attended Dr Ho.

70. There is no expert opinion as to how long a trial of medicinal cannabis should last. It may be that Dr Ho considers that trials for medicinal cannabis should at this stage continue in general medical practice because he writes that "there is poor scientific evidence for the efficacy or safety at this stage." I read this opinion as being in relation to the use of medicinal cannabis generally, rather than to the applicant's individual situation.

71. The applicant saw A/Prof Molloy one month after he attended Dr Ho. A/Prof Molloy records the applicant commencing medicinal cannabis treatment in July 2018. A/Prof Molloy's own recommendation is that the applicant undertake an intensive cognitive behavioural pain management program as the best way forward to manage the applicant's ongoing pain. However, A/Prof Molloy does not recommend against the medicinal cannabis treatment undertaken by the applicant, even though he also opines that the use of medicinal cannabis in the applicant's case is complex and that the applicant remains distressed and disabled at the present time. A/Prof Molloy does not query the length of time that the applicant has been having treatment while still taking some opiate medication as well.

72. I accept the opinions of those doctors who have recently treated the applicant, being Dr Towpik, Dr Holtzman and Dr Ho, that the applicant's medicinal cannabis treatment has improved his response to pain, and has thereby alleviated the consequences of his injury. Those doctors are in the best position to provide such an opinion in their role as treating doctors.

73. Although an alternative means of treatment for pain relief has been recommended by both Dr Ho and A/Prof Molloy by way of an intensive pain management program, that does not mean that the medicinal cannabis treatment is not reasonably necessary. A patient can be offered different treatments which aim for the same result, which in this case is the reduction of longstanding pain experienced by the applicant.

74. I have not had any regard for the opinion of Mr Hijazi because not only has he not had the benefit of speaking directly with the applicant, it is apparent from his report that there is a fundamental error in the chronology which he records of the applicant's treatment with medicinal cannabis. Mr Hijazi states that the applicant ceased using medicinal cannabis in October 2019 and that the applicant's use of narcotic analgesics significantly increased. This becomes a basis for Mr Hijazi to question the efficacy of this treatment.

75. However, it is clear from the evidence that the applicant has continued to use medicinal cannabis since June 2018. In my view, the opinions of Mr Hijazi are flawed given this fundamental error in his understanding of the applicant's treatment.

76. Mr Robertson submits that if the applicant had been able to significantly reduce or eliminate his use of opioid medication, then the respondent may take a different position in regard to the applicant's medicinal cannabis treatment. It seems to me that the aim of having the medicinal cannabis treatment is to significantly reduce, if not eliminate, the need for opioid medication. A/Prof Molloy is certainly concerned that the ongoing use of opioid and cannabis medication means that the applicant remains distressed and disabled.

77. I have accepted the evidence of those doctors who have treated the applicant that the applicant has reduced his intake of opioid medication, but the applicant has continued to take both opioid and cannabis medication for the past two years. The applicant states that Oxycontin, Tramadol, Endone and Panadeine Forte do not give him much pain relief but he continues to take those medications. Dr Towpik writes that those medications were ineffective for the applicant.

78. While I have accepted that, based upon the opinions of those doctors who have treated the applicant, the medicinal cannabis treatment which the applicant has undertaken to date is reasonably necessary in alleviating the consequences of the applicant's injury, I do not propose to make any order for future treatment.

79. Section 60 (5) of the 1987 Act provides:

> "(5) The jurisdiction of the Commission with respect to a dispute about compensation payable under this section extends to a dispute concerning any proposed treatment or service and the compensation that will be payable under this section in respect of any such proposed treatment or service. Any such dispute may be referred by the Registrar for assessment by an approved medical specialist under Part 7 (Medical assessment) of Chapter 7 of the 1998 Act."

80. There is no proposed treatment set out in the reports of Dr Holtzman or Dr Ho regarding the applicant's medicinal cannabis treatment and I therefore do not intend to make order for future treatment which is provided for by section 60 (5).

81. If the applicant continues with the medicinal cannabis treatment then in the absence of approval by the respondent, he will need to seek to recover the cost of that treatment pursuant to the indemnity provision that is allowed for by section 60 of the 1987 Act (see *NSW Sugar Milling Co-op v Manning* [1998] NSWCC 33; (1998) 44 NSWLR 442). If that were to occur, then I would expect there to be expert opinion which addresses whether it is appropriate for the applicant to continue to have medicinal cannabis treatment if he is also still taking significant amounts of opioid medication.

82. There will be an order that the respondent meets the cost of medicinal cannabis treatment incurred by the applicant to date.