WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3595/20**
Applicant: **Troy Eve**
Respondent: **Matthews Contracting Pty Ltd**
Date of Determination: **28 August 2020**
Citation: **[2020] NSWWCC 291**

The Commission determines:

1. The surgery proposed by Dr John Garvey is reasonably necessary as a result of the applicant's injury.

The Commission determines:

2. The respondent to pay the reasonably necessary costs of, and incidental to, the surgery proposed by Dr Garvey pursuant to section 60 of the *Workers Compensation Act 1987*.

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

Jill Toohey
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 JILL TOOHEY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. In March 2016, the applicant, Troy Eve, started work as a full-time truck driver for the respondent, Matthews Contacting Pty Limited. His duties included carting building materials, equipment and plant.

2. In August 2016, Mr Eve underwent a laparoscopic left inguinal hernia repair following which he returned to his pre-injury duties.

3. On 24 January 2017, Mr Eve felt a "ripping sensation" in his left abdomen/groin area while lifting a heavy bag of concrete. By the time he arrived home that evening, the pain had increased. He attended the Mona Vale Hospital where an ultrasound revealed a strangulated hernia. Surgery could not be performed because he had already eaten. He was kept in overnight and underwent emergency surgery under Dr Samuel Kuo the following day.

4. The respondent accepted liability for Mr Eve's injury.

5. Mr Eve has seen a number of specialists since then and has undergone various procedures and treatments including perineural injections, and further surgery in July 2018. He continues to experience severe pain in the region of his left groin.

6. In July 2019, Mr Eve saw Dr John Garvey, general and diagnostic surgeon and herniologist, who recommended an exploratory operation of the left groin. Mr Eve claims the reasonably necessary costs of the proposed surgery pursuant to section 60 of the *Workers Compensation Act 1987* (the 1987 Act).

7. By a notice issued on 14 August 2019 under section 78 of the *Workplace Injury Management and Workers Compensation Act 1998* and review notices issued on 12 February 2020 and 20 March 2020, the respondent denies liability to compensate Mr Eve for the cost of the proposed surgery on the ground that it is not reasonably necessary as a result of his workplace injury.

ISSUES FOR DETERMINATION

8. The parties agree that the only issue remaining in dispute is whether the surgery proposed by Dr Garvey is reasonably necessary.

PROCEDURE BEFORE THE COMMISSION

9. The parties attended a conciliation conference and arbitration hearing on 19 August 2020. Mr David Baran of counsel appeared for Mr Eve. Ms Lyn Goodman of counsel appeared for the respondent. 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.

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 and attached documents;

    (b) Reply and attached documents;

    (c) Application to Admit Late Documents lodged by the respondent on 28 July 2020 and attachments;

    (d) Application to Admit Late Documents lodged by the applicant on 10 August 2020 and attachments.

Oral evidence

11. Neither party sought leave to adduce oral evidence or to cross-examine any witness.

FINDINGS AND REASONS

12. There is no dispute as to the circumstances of Mr Eve's injury. There is no dispute that he continues to suffer severe pain. The dispute centres on whether the exploratory surgery recommended by Dr Garvey is reasonably necessary. The following is a summary of Mr Eve's statement of evidence dated 29 April 2020 and uncontroverted history from the medical reports.

13. In a statement dated 24 April 2020[1], Mr Eve states that, almost straight after the surgery performed by Dr Kuo on 25 January 2017, he started to have extreme and ongoing pain extending into his left testicle.

14. In March 2017, Mr Eve saw Dr Kuo again. He was still having significant pain. An ultrasound of his left hip on 29 March 2017 showed no pathology of consequence, and an MRI of the left groin on 8 June 2017 showed only small bilateral hydrocoeles. Dr Kuo suggested the pain could be nerve pain and referred Mr Eve to pain specialist, Professor Michael Cousins.

15. Mr Eve saw Professor Cousins in July 2017. He recommended a cortisone injection in the groin which was performed on 19 October 2017. Following the injection, the pain increased.

16. In August 2017, Mr Eve saw Associate Professor Paul Myers, general and vascular surgeon, at the request of the respondent. Associate Professor Myers provided reports dated 28 August 2017, 9 December 2019, 2 June 2020 and 6 July 2020.

17. In December 2017, Mr Eve saw surgeon Dr Ibrahim for a second opinion. Dr Ibrahim recommended a further injection which was performed by Dr Reid on 15 January 2018. There was still no improvement and Dr Ibrahim referred him to another doctor for a further injection. The doctor declined to perform the injection, saying it would not help.

18. In April 2018, Mr Eve was referred to psychiatrist Dr Mobbs for reactive depression due to his chronic pain.

[1] ARD 1

19. On 8 May 2018, Dr Kuo referred Mr Eve to Dr Hanh Tran, consultant general and laparoscopic surgeon, and director of the Sydney Hernia Specialists Clinic. Dr Tran recommended a procedure involving mesh repair and removal of the external mesh. In July 2018, Mr Eve underwent the procedure, originally to be laparoscopic, but performed by open operation. The pain in his testicle mostly resolved but the pain in his groin continued. He continued to see Dr Tran for management. He was left with “significant scarring” which he says Dr Tran did not tell him about.

20. In January 2019, Mr Eve felt a sudden, sharp pain in his groin. His left leg gave way and he fell, injuring his left arm and shoulder. The arm and shoulder injury is not relevant to these proceedings.

21. In March 2019, Mr Eve started work driving trucks for another company. He ceased work on May 2019 on account of his severe groin pain. In June 2019, his general practitioner arranged an MRI of his lower back which showed some facet joint changes and possible femoro-acetabular impingement at the left hip.

22. On 17 June 2019, Mr Eve attended at the emergency department of Northern Beaches Hospital with severe groin pain. No reason for the pain could be found and he was discharged.

23. Mr Eve saw Dr Tran again on 26 June 2019. Dr Tran considered there was some sensation coming back into the left groin, and nerves growing back after the surgery in July 2018. He recommended Mr Eve continue taking Lyrica, Tramal, Panadeine Forte, and Endone at night, for a further six weeks.

24. Mr Eve requested review by another surgeon as the medication was not working. On 18 July 2019, he saw Dr Garvey who ordered new scans and recommended exploratory surgery with a possibility of conjoint tendon repair and “fixing any other issues while in there”[2]. Dr Garvey considered there was evidence of left S1 radiculopathy and L5 myotone clonus but a negative lumbosacral MRI scan. He found signs of left hip pathology and a fixed flexion contracture of the left knee. He recommended further surgery, stating he was unsure what procedure Dr Tran had carried out.

25. In a report dated 12 August 2019, Dr Tran disagreed with Dr Garvey’s recommendation for further surgery, in particular conjoint tendon repair. On 14 August 2019, the respondent denied liability to pay for the surgery proposed by Dr Garvey.

26. On 29 August 2019, Mr Eve saw Dr Peter Endrey-Walder, general and trauma surgeon, for assessment. Dr Endrey-Walder provided reports dated 29 August 2019, 27 February 2020 and 10 June 2020.

27. In November 2019, Mr Eve started seeing Dr Charles Brooker, pain medicine specialist, after Professor Cousins retired. Dr Brooker provided a report dated 13 June 2020.

28. On 29 November 2019, Mr Eve attended at Royal North Shore Hospital emergency department with extreme pain and urinary retention. He was an inpatient for about a week. He was readmitted on 28 January 2020 with the same symptoms. A catheter was inserted and two metal clips were found inside his bladder. They were removed and he was an inpatient until 6 February 2020.

29. Mr Eve states that he has been sent from doctor to doctor. He has not worked since May 2019 because of the severe pain. As well as his general practitioner, he sees Dr Brooker and Dr Garvey. Hydrotherapy and physiotherapy have not relieved the pain. He sees a psychologist and a psychiatrist.

[2] ARD 4

30. Mr Eve describes[3] his current symptoms as extreme throbbing pain extending from the top of his left leg through his abdominal region towards his left side. He gets pain in his penis and reproductive area and back into his testicle. He has pain all day, every day. He cannot sit for longer than 10 minutes without pain developing. He cannot lie on his back and sleeps in a reclining chair which the insurer paid for. He has no sex life. He cannot work. The pain affects all aspects of his life. No one can give him a diagnosis. He requires the surgery recommended by Dr Garvey.

Dr Garvey's reports

31. Dr Garvey reported to the insurer on 18 July 2019[4]. He set out the history including the operation performed by Dr Tran in July 2018 which Dr Garvey said "sounded like an endoscopic triple neurectomy and endoscopic mesh replacement". He noted that Mr Eve was now troubled by a different testicular pain from that for which he had attended at Northern Beaches Hospital.

32. With respect to the diagnostic imaging, Dr Garvey noted the left hip appeared normal following the surgery in March 2017, the MRI in June 2017 showed normal post-surgical changes in the left inguinal region and incidental small bilateral hydrocoeles, and there was nothing of note in an ultrasound of the left lumbar region in October 2018 or in a bone scan of the lumbosacral spine and pelvis in April 2019. The MRI of the lumbar spine and left groin in June 2019 showed no cause for chronic groin pain.

33. Dr Garvey said this was a "most unusual case". There were signs of left sided groin disruption injury unresponsive to mesh implantation and, on the other hand, evidence of left S1 radiculopathy, and L5 myotone clonus but a negative lumbosacral MRI scan. There were signs of left hip pathology and a fixed flexion contracture of the left knee. The only objective abnormal findings were elevated levels of blood sugar, cholesterol and so on.

34. Dr Garvey recommended that investigations start again with further diagnostic imaging. On reviewing Mr Eve with the results, Dr Garvey reported that the physical signs were a little worse than the previous week. He reported the results of his examination including that testing of the conjoint tendon was painful. He concluded that Mr Eve needed an "exploratory operation of the left groin"[5]. He said he could not tell whether the mesh needed to be removed but the spermatic cord needed to be explored and nerves released and "probable conjoint tendon repair".

35. On 5 June 2020[6], Dr Garvey reported to Mr Eve's solicitors. He set out the history and diagnostic imaging, much of which was identical to his earlier report. He said Mr Eve returned for review on 9 April 2020 and was "still in agony from pain in his left groin"[7]. Dr Garvey reported:

> " I am strongly of the opinion that he requires a left groin exploration surgery and I note that Dr Charles Brooker Pain Management Specialist and the Attending Medical officers in the Emergency Department of Royal North Shore Hospital are of the same view. It is difficult to say at this time whether his left conjoint tendon is involved with the injury because his left groin pain is so extreme to palpation."

[3] ARD 5

[4] ARD 46. The report is dated 18 July 2019 but includes results of the further imaging and further consultation on 27 July 2019.

[5] ARD 48

[6] ARD 40

[7] ARD 42

36. As to why the proposed surgery was reasonably necessary, Dr Garvey said:

> "This Worker needs a left groin exploratory operation which would consist of removal of the mesh and reconstruction with a non-mesh repair. The rationale for this being that mesh is a foreign material to the human body [which] excites a chronic foreign body granulomatous inflammatory reaction which is [sic] encompasses all surrounding border nerves casing severe pain. It is unclear to me on physical examination whether the conjoint tendon needs repair but I will make that decision at the time of surgery as discussed and agreed with the Worker. There may be other findings that require surgical attention at this exploratory operation such as nerve entrapment or neuroma resection."

37. With respect to Associate Prof Myer's opinion (below), Dr Garvey agreed that the femoro-acetabular impingement might have an etiological role on the injury. He said he could not specifically examine the left conjoint tendon because Mr Eve was in so much pain but he would examine it during surgery and perform a repair if necessary. He said the inguinal mesh needed to be removed because of the condition known as *mesh inguinodynia* which causes pain in 4-10% of patients who have mesh implanted.

38. Dr Garvey cited his experience with mesh explantation and recurrent groin reconstruction in over 110 patients, and an abstract submitted to the Americas Hernia Society annual meeting in September 2020. He said Mr Eve had had all the necessary test injections of the border nerves of the left groin without any benefit. He said he had no desire to be involved in any argument with Associate Prof Myers but simply relied on his own experience of treating chronic groin pain due to mesh inguinodynia overt the past 15 years.

39. Dr Garvey maintained that most cases of severe inguinodynia benefit from exploratory surgery. He said he did not think one could rely on "past treatments by other surgeons with less experience" and, more often than not, some issue that had been badly managed, undetected or ignored was found. In the majority of cases, he said, the cause of the problem is found and significant pain relief effected.

40. On 6 August 2020[8], Dr Garvey reported to Mr Eve's solicitors in response to Dr Tran's last report (below) and Associate Prof Myers' reports. Dr Garvey stated why he thought the proposed procedure reasonably necessary. He said the definition of "groin injury" has never been agreed on by experts, and the surgical world is moving away from mesh implantation for hernia repair.

41. Dr Garvey acknowledged that re-explorations put the testicle and spermatic cord at risk, and there was a 2% chance of Mr Eve losing his testicle as a result of the procedure. He said femoro-acetabular impingement is relevant to chronic groin pain and a referral is not made to an orthopaedic hip specialist without good indications. He said it was not clear whether Mr Eve had a conjoint tendon injury because he was in so much pain on three occasions and it could not be unequivocally tested. He said he relied on the findings of the ultrasound in July 2019 that showed involvement of the conjoint tendon as the site of maximum pain. Surgical exploration remained the next approach in his view.

42. In response to questions raised by Dr Tran and Associate Prof Myers about Medicare items, Dr Garvey explained his use of each. He concluded that there was no doubt this was a difficult case and surgery was not recommended lightly but he remained of the view it was Mr Eve's best chance of relieving his pain and returning to work.

[8] Application to Admit Late Documents, 10 August 2020

Dr Tran's reports

43. A number of reports from Dr Tran are in evidence.[9] In the first, dated 30 May 2018 to Dr Kuo, Dr Tran set out a detailed history. He said Mr Eve's symptoms and signs were "classical of neuropathic pain post open groin hernia repair".[10] He recommended the procedures which, subsequently, he performed on 5 July 2018.

44. Dr Tran saw Mr Eve on 12 July 2018 and reported[11] that he was still sore as would be expected after extensive surgery. On 8 August 2018, he had an "ill-defined area of pain"[12] above the scar which Dr Tran said was almost certainly surgical pain which could take three months to settle. On review throughout August, September and October 2018, he still had some pain, and an area of numbness "likely to representing [sic[nerve sprouting from the surrounding area"[13] which would become less although it could take several years.

45. On 19 February 2019[14], Dr Tran reported that Mr Eve was still having some left groin pain. He said the simplest way to deal with it was non-steroid anti-inflammatory medication and an ultrasound guided injection.

46. On 12 August 2019,[15]Dr Tran reported to the insurer following Mr Eve's consultation with Dr Garvey. Dr Tran said there was no justification for a "so-called conjoint tendon repair". He maintained his opinion that Mr Eve should continue with pain medication. He did not believe Mr Eve would benefit from further surgical interventions for the foreseeable future. In a post-script, Dr Tran included a "Google review for Dr Garvey" from a dissatisfied patient following mesh removal and recurrent inguinal hernia repair for groin pain by Dr Garvey.

47. In a report dated 15 June 2020[16], Dr Tran stated with a "definitive NO" that the treatment proposed by Dr Garvey was not "necessary medical treatment". He said Mr Eve suffers from chronic pain syndrome, the treatment for which is not more surgery which would make it much worse, apart from causing potentially life-threatening complications.

48. Dr Tran took issue with the Medicare items quoted by Dr Garvey which included "Exploration of spermatic cord, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis". Dr Tran said he saw no benefit from this exploration and it was naïve to even think it would somehow get rid of Mr Eve's pain. Additionally, it would be third exploration, meaning a very significant risk of damaging the blood supply to the left testicle, with almost certainty that Mr Eve could lose his testicle.

49. Dr Tran said "multiple opinions", including his own, had repeatedly said there was no justification for a conjoint tendon repair as proposed by Dr Garvey. Dr Tran said the removal of the externally placed mesh which caused Mr Eve's chronic groin pain was "meticulously performed", and he described the procedure in detail. He described the numbness that follows trineurectomy which he said decreases in time, as photographs of pin-prick sensation tests which he had provided, had demonstrated. Dr Tran disagreed with one aspect of Associate Prof Myers' report but agreed with his "astute statement" that it was unlikely that Mr Eve would get much in the way of symptomatic relief from the proposed surgery.

50. Dr Tran thought it "very strange" that Dr Garvey had made no attempt to refer Mr Eve to an orthopaedic surgeon when scans showed, amongst other lumbar pathologies, femoro-acetabular impingement syndrome which is known to cause significant and increasingly pain over time.

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[9] From Reply 9
[10] Reply 10
[11] Reply 27
[12] Reply 30
[13] Reply 33
[14] Reply 37
[15] Reply 40
[16] Reply 79

51. Dr Tran went on to describe his credentials in hernia surgery, including working almost exclusively in hernia surgery since 2005 and over 4,000 laparoscopic inguinal hernia repairs and some 400 laparoscopic ventral/incisional hernia repairs. He described his academic qualifications and published research papers.

52. Dr Tran concluded that, three years after the original surgery, Mr Eve is suffering from chronic pain syndrome, the treatment for which includes expert pain management with neuromodulation with medications, physiotherapy, psychotherapy, rehabilitation, skill retraining and other potential neurosurgical interventions. Targeted nerve injections may help. He was also aware of other treatment modalities including implantation of electrodes in the groin but there were only anecdotal reports of their success in a small number of patients and he has no experience with them. He also thought the femoro-acetabular impingement syndrome would need to be addressed by an experienced orthopaedic surgeon.

53. Dr Tran reported on 23 July 2020[17] in response to specific questions and added comments on "Dr Garvey's opinions and his so-called expertise and even superiority in hernia management and its complications". Dr Tran restated his reasons for disagreeing with Dr Garvey.

54. It is fair to say that much of Dr Tran's report is given over to his superior expertise in inguinal hernia repairs and what he regards as Dr Garvey's lack of experience, in fairly intemperate language. For example, he said "The Garvey [sic] seems hell bent on performing the conjoint tendon repair despite scientific evidence to the contrary including an opinion from Dr Myers." He said he is aware of "some serious sequelae" from surgery performed by Dr Garvey, and is denigrating of his experience. He refers to the likely result of surgery as "a multitude of potential life-threatening complications" as he had previously enunciated. He maintained there are many other management avenues including "pharmacological neuromodulation, psychological/psychiatric, orthopaedic […] transcutaneous nerve stimulation, dorsal root ganglion stimulation etc".

Associate Prof Myers' reports

55. Associate Prof Myers reported to the insurer on 9 December 2019[18], having first seen Mr Eve in August 2017. He had reports from Dr Tran and Dr Garvey. He noted it was "not clear what operation [was] done by Dr Tran". He could see no indication for the probable conjoint tendon repair proposed by Dr Garvey. He was "puzzled" by Dr Brooker's support (below) for Dr Garvey's surgical plan because Dr Brooker not a surgeon and has no surgical expertise.

56. Associate Prof Myers said he suspected some of Mr Eve's more diffuse pain was due to the femoro-acetabular impingement syndrome but, regardless, he had neuropathic pain syndrome related to the ilio-inguinal nerve and more broadly. He noted the various treatments to date. He concluded that further pain medication advocated by Dr Tran might control symptoms but would not change any underlying issues. He could see no justification in a conjoint tendon repair proposed by Dr Garvey. If any procedure was to be performed it would be dividing the ilio-inguinal nerve as far proximally as possible. He thought it unlikely Mr Eve would get any relief from Dr Garvey's proposal. Injections of a long-acting local anaesthetic and/or steroid around the nerve "may be worthwhile".

57. On 2 June 2020, Associate Prof Myers provided a supplementary report[19]. He stated he did not consider the procedures proposed by Dr Garvey to be reasonably necessary and he queried the Medicare item numbers cited by Dr Garvey. He saw no justification for removing the mesh used initially to repair the inguinal hernia; it would be the fourth operation on the

[17] Application to Admit Late Documents, 28 July 2020
[18] Reply 51
[19] Reply 74

groin and would carry an increased risk of complications including significant risk of recurrent herniation. He thought Mr Eve should have further injections and thought further invasive surgery of the kind proposed by Dr Garvey would likely leave him worse off.

58. In a further report dated 6 July 2020[20], Associate Prof Myers commented on Dr Garvey's report of 5 June 2020, Dr Brooker's report of 7 May 2020 and Dr Tran's report of 15 June 2020. He said there was "absolutely no evidence" for Dr Garvey's assertion that Mr Eve's known femoro-acetabular impingement syndrome has caused some restricted range of movement of the hip causing compensatory movement across the midline of the pubic symphysis and soft tissue disruption. He said the insertion of mesh in the groin does result in some people suffering non-specific pain in the groin for reasons which are not clear.

59. Associate Prof Myers said his feeling was that removing what mesh is currently in place is unlikely to make any difference to Mr Eve's pain, and the surgery would be difficult and would come with significant complications. He thought the likelihood of any or all of the major complications as described by Dr Tran was unlikely, but certainly possible. More likely would be that a repair would not be successful and Mr Eve would then be left with a problem of recurrent herniation. In conclusion, his opinion remained unchanged and there was little likelihood of benefit from the proposed surgery.

Dr Endrey-Walder's reports

60. Dr Endrey-Walder saw Mr Eve for assessment on 29 August 2019[21]. He took a detailed history and had relevant reports. He said he had some difficulty establishing the exact pathology, and he was handicapped without clarification as to what Dr Tran performed in July 2018. He said he had some sympathy with Dr Tran's view that Mr Eve should not have further surgery but he would like to know the exact procedure Dr Tran carried out. That said, two facts were "incontestable": that Mr Eve's groin pain was not in any way related to his lumbar spine, and he did not have a recurrent hernia.

61. On 27 February 2020[22], Dr Endrey-Walder reported on the advisability or otherwise of the proposed surgery. He recited a detailed history including that Dr Samra, surgeon, recommended exploration of the groin during Mr Eve's admission to hospital in January 2020. He said his findings on examination were identical to his previous examination.

62. Dr Endrey-Walder said he had now had Dr Tran's operation report of 5 July 2018. Given that report and the nature of Mr Eve's ongoing pain, he said one must presume that he had one or more small neuromas as they relate to severed nerves. If so, "nothing short of exploration and excision of such a lesion will have any beneficial effects on [his] symptoms".[23] He was not convinced that conjoint tendon repair was necessary but exploration of the medical end of the inguinal canal and the scrotum would be reasonable. Another reason for agreeing to exploration of the groin was his "abject symptomatology and functional deficit" for more than three years and nothing else promises to make any difference to his condition.

63. On 10 June 2020[24], Dr Endrey-Walder reported in response to Mr Garvey's report of 5 June 2020 in which he said exploration of the left conjoint tendon was not possible on account of Mr Eve's severe pain. Dr Endrey-Walder in the context of the proposed exploration of the groin, Dr Garvey's recommendation was reasonable, and he accepted that the condition of the back of the inguinal canal could not be ascertained until explored surgically.

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[20] Reply 69
[21] ARD 26
[22] ARD 34
[23] ARD 36
[24] ARD 38

Dr Brooker's report

64. Dr Brooker reported to Mr Eve's solicitors on 13 June 2020[25]. He recommended continuing physiotherapy and clinical psychology consultations. He said he also recommended Mr Eve proceed with Dr Garvey's recommendations. He said he was cautious about recommending surgery but he had continuing pain, the cause of which is poorly defined both in general and in his case. Dr Brooker said in many patients the nerves are damaged and this is thought to cause the ongoing pain syndrome. He said there is literature supporting reoperation for recurrent hernia and removal of mesh is sometimes appropriate.

65. Dr Brooker said Dr Garvey's assessment was detailed and comprehensive and he outlined the uncertainties in the case. He found no reason to disagree with Dr Garvey's recommendations. He did not think injections have any meaningful impact on pain because of their transitory nature and he would not recommend them. He did not think that femoro-acetabular impingement syndrome was causing Mr Eve's current symptoms, for reasons he outlined in his report.

66. Dr Brooker concluded by acknowledging that he is not a surgeon, as Associate Prof Myers had pointed out. However, as a pain management specialist, he has a role in advocating for appropriate surgical recommendations to be followed by the patient. He said while the literature supports reoperation hernia surgery in some circumstances, it is well-known that some patients do not respond and in fact sometimes get worse. He said it is "a very difficult decision"[26] but he continued to support Dr Garvey's recommendation for surgical exploration.

The applicant's submissions

67. Mr Baran submits that this case involves a complex medical issue but the legal principles are clear. He refers to the decisions in *Rose v Health Commission (NSW)*[27], *Bartolo v Western Sydney Area Health Service*[28] and *Diab v NRMA*[29].

68. Mr Baran submits there are many cases in which what is said to be unorthodox treatment has been found to be reasonably necessary, although he does not say that what Dr Garvey proposes is unorthodox. Mr Baran refers to cases in which the Commission has found stem cell therapy to be reasonably necessary including *Warn v Flight Centre Limited*[30] and *Vincent Kenney v Above Scaffolding Pty Ltd*[31], and *Kjaersgaard v Touraust Pty Limited t/as Country Comfort Hotel*[32] in which acupuncture was found to be reasonably necessary.

69. In Mr Baran's submission, Dr Tran launched a vociferous attack on Dr Garvey's qualifications and the proposed procedure which he asserts is not backed up by evidence. In contrast, Mr Baran submits, the decision in *Sohn v Baptist Community Services (NSW & ACT)*[33] involved a similar case in which proposed exploratory surgery by Dr Garvey of an inguinal mesh plug was found reasonably necessary.

70. Mr Baran submits that Dr Tran's attack on Dr Garvey is unjustified and because he was justifiably concerned at the outcome of the procedure he had undertaken. Dr Garvey is eminently qualified. Dr Tran's reports lack objectivity and should be given little weight.

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[25] ARD 51

[26] ARD 55

[27] *Rose v Health Commission (NSW)* [1986] NSWCC 2; 2 NSWCC 32 (*Rose*)

[28] *Bartolo v Western Sydney Area Health Service* [1997] NSWCC 1; 14 NSWCCR 223 (*Bartolo*)

[29] *Diab v NRMA* [2014] NSWWCCPD 72 (*Diab*)

[30] *Warn v Flight Centre Limited* [2016] NSWWCC 253 (*Warn*)

[31] *Vincent Kenney v Above Scaffolding Pty Ltd* [2019] NSWWCC 41 (*Kenney*)

[32] *Kjaersgaard v Touraust Pty Limited t/as Country Comfort Hotel* WCC006983 – 2008 (*Kjaersgaard*)

[33] *Sohn v Baptist Community Services (NSW & ACT)* [2013] NSWWCC 108 (*Sohn*)

71. Mr Baran submits that none of the treatment so far has worked. Dr Garvey does not suggest surgery will be a panacea but Mr Eve has pain where the previous surgery was performed, there are irregularities in that staples were found still in his bladder, he has severe pain into the testicular area, and he has run out of all non-invasive options. Dr Garvey does not suggest that further surgery is to be undertaken lightly.

72. In Mr Baran's submission all that Mr Eve is required to show is that, in the hands of an experienced surgeon such as Dr Garvey, his symptomatology will be alleviated to some degree. Diagnostic methods to date including ultrasound and other imaging have been unable to offer a precise diagnosis. Having tried everything else, Mr Eve is prepared to undergo the procedure so he can get some relief and get back to work. There is a good deal of debate between the experts but no one other than Dr Tran, who has his own agenda, suggests another way will get him back to work.

73. Considering the principles in *Rose*, *Bartolo* and *Diab*, Mr Baran submits that, more probably than not, there will be some better outcome for Mr Eve from the proposed surgery.

74. Mr Baran refers to the decision of the Supreme Court in *Tinnock v Murrumbidgee Local Health District (No 6)*[34], in which the plaintiff was awarded over $1 million in damages in a medical negligence claim involving severe post-operative infection associated with surgical mesh following incisional hernia repair. Mr Baran submits the case involved extensive expert evidence about complications associated with surgical mesh, and no doubt mesh works in many cases but Mr Eve's is not one of them.

The respondent's submissions

75. Ms Goodman submits that one needs to go through the medical evidence to see what Dr Tran did in July 2018, Mr Eve's recovery post that surgery, and the evidence about the risks associated with the proposed surgery.

76. Ms Goodman submits that Dr Tran has provided clear information about the surgery he performed In July 2018 including a histological report. He disputes the need for exploration when the histology report shows that is what was done, and Mr Eve did quite well following surgery. By July 2018, he was still sore, as was to be expected, but he could walk reasonably well. By August 2018, his pre-operative chronic neuropathic pain had largely disappeared, and he continued to improve.

77. In February 2019, Mr Eve told Dr Tran his groin pain had gone but a more medial pain remained in and around the public tubercle area. Dr Tran explained the reason and recommended non-steroid anti-inflammatory medication and an ultrasound-guided steroid injection. He explained the difficulties associated with removing mesh. By this time Mr Eve had gone back to work and the pain was nothing like it had been previously. In June 2019, there was a different kind of pain, in the left testicle.

78. Ms Goodman submits that Dr Tran was emphatic is stating there are serious risks associated with Dr Garvey's proposal. He responds fully to Dr Garvey and notes that he made no effort to refer Mr Eve for an orthopaedic opinion.

79. Ms Goodman submits that Associate Professor Myers agrees with Dr Tran and can find no justification for the proposed surgery. Moreover, he says Mr Eve is likely to end up worse off. He and Dr Tran say Dr Garvey has not properly explained the rationale for the exploratory surgery. Essentially, both say the surgery is not reasonably necessary.

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[34] *Tinnock v Murrumbidgee Local Health District (No 6)* [2017] NSWSC 1003 (28 July 2017) (*Tinnock*)

The applicant’s submissions in reply

80. In reply, Mr Baran submits that Dr Garvey’s report of 6 August 2020 which refers to the ultrasound findings which show involvement of the conjoint tendon as the main source of pain. Dr Garvey and Dr Endrey-Walder agree there are no orthopaedic issues as suggested by Dr Tran. All the doctors agree something is wrong and they have different views. Everything so far has failed, Mr Eve needs to exploratory surgery, and he ought to have it.

Is the proposed surgery reasonably necessary treatment?

81. Section 60 of the 1987 Act relevantly provides:

> “(1) If as a result of an injury received by a worker, it is reasonably necessary that:
>
> (a) any medical or related treatment (other than domestic assistance) be given, or
> (b) any hospital treatment be given, or
> (c) any ambulance service be provided, or
> (d) any workplace rehabilitation service be provided,
>
> the worker’s employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2).”

82. In *Rose*, Burke CCJ considered what reasonably necessary treatment was. In the context of section 10 of the *Workers Compensation Act 1926* he said:

> “Treatment, in the medical or therapeutic context, relates to the management of disease, illness or injury by the provision of medication, surgery or other medical service designed to arrest or abate the progress of the condition or to alleviate, cure or remedy the condition. It is the provision of such services for the purpose of limiting the deleterious effects of a condition on restoring health. If the particular ‘treatment’ cannot, in reason, be found to have that purpose or be competent to achieve that purpose, then it is certainly not reasonable treatment of the condition and is really not treatment at all. In that sense an employer can only be liable for the cost of reasonable treatment.”[35]

83. His Honour added[36]:

> “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.
>
> 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.
>
> 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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[35] At [42]
[36] At [47]

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."[32]

84. In *Bartolo*, His Honour considered the factors relevant to reasonably necessary treatment for the purposes of s 60 and stated:

> "The question is should the patient have this treatment or not. If it is better that he have it, then it is necessary and should not be forborne. If in reason it should be said that the patient should not do without this treatment, then it satisfies the test of being reasonably necessary."[37]

85. In *Diab*, DP Roche questioned this approach. Citing *Rose* with approval, he summarised the applicable principles as follows:

> "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.
>
> 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.
>
> 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."[38]

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[37] At [238]
[38] At [88] to [90]

86. DP Roche also noted in *Diab*:

> "... [d]epending on the circumstances, a range of different treatments may qualify as "reasonably necessary" and a worker only has to establish that the treatment claimed is one of those treatments."[39]

87. There is no dispute in this case that Mr Eve has serious, ongoing pain as a result of his workplace injury.

88. There is no dispute among the doctors that Mr Eve's condition is medically complex. Its complexity can be seen from their varying opinions as to the possible and likely causes of his pain, the significance of particular factors such as femoro-acetabular impingement syndrome, and the risks associated with the proposed surgery. Dr Tran, for example, posits life-threatening complications arising from the proposed surgery but Associate Prof Myers, who supports Dr Tran as to the overall prospects of success, thought the major complications described by Dr Tran were unlikely, though certainly possible. Dr Endrey-Walder, who broadly supports Dr Garvey, was not convinced that conjoint tendon repair was necessary but exploration of the medical end of the inguinal canal and the scrotum would be reasonable.

89. Mr Baran referred me to decisions in which the Commission has found novel treatments have been found to be reasonably necessary. In *Warn*, stem cell therapy was found to be reasonably necessary where all other modalities had failed to ameliorate the workers excruciating pain following a head injury and subsequent complications. The fact that the proposed treatment was somewhat experimental was not considered adequate reason in the circumstances. While its effectiveness was unproven, the Commission said that had to be weighed against the worker's excruciating pain; if there was any chance of ameliorating that pain, she deserved that opportunity.

90. *Kenney* also involved proposed stem cell therapy. The effectiveness of the treatment for a lumbar spine injury was in dispute. The Commission accepted that it was "somewhat novel" but there was a "real chance which was neither far-fetched nor fanciful"[40] that it would afford the worker some relief. Its potential effectiveness had to be weighed against the position the worker found himself in, being a great deal of pain. There was a chance it would provide at least partial relief of his symptoms and improve his quality of life, and he should have that opportunity.

91. In *Kjaersgaard*, the Commission found acupuncture to be reasonably necessary treatment for chronic neck and shoulder pain. That case was different insofar as the worker had already had the treatment and said it helped her manage her pain and provided some level of relief.

92. I have found these cases of limited assistance because each went primarily to the likely effectiveness of novel procedures. In the present case, as I understand the evidence and submissions, the dispute is not so much that the proposed surgery is novel but rather that its likely effectiveness and potential risks are disputed.

93. Mr Baran also referred me to the decision in *Sohn*, in which the facts were not dissimilar to the present case. The issue was whether "exploration, removal of inguinal and possibly mesh plug and left triple neurectomy of the iliohypogastric, ilioinguinal and genitofemoral nerves" as proposed by Dr Garvey was reasonably necessary. Dr Berry, for the respondent, considered it unlikely it would change the worker's condition which was slowly improving.

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[39] At [86]
[40] At [22]

94. In *Sohn*, the worker had an open repair for a left inguinal hernia following which she had chronic pain. Dr Berry and Dr Garvey differed as to the likely source of her pain and the likely effectiveness of the proposed surgery. Dr Garvey agreed with Dr Berry that it had the potential to worsen her condition or at least might not afford her any significant pain relief. A further specialist agreed with Dr Berry. The Arbitrator preferred Dr Garvey's opinion and was satisfied there was a reasonable chance of a successful outcome and the treatment was competent to alleviate some of the worker's symptoms.

95. Each case has to be decided on its merits. It does not follow because surgery is found to be reasonably necessary in one case that it is reasonably necessary in another. However, whereas Dr Tran was dismissive of Dr Garvey's "so-called" expertise in the field, *Sohn* tends to illustrate it.

96. Mr Baran also referred to the judgment of the Supreme Court in *Tinnock* in which the plaintiff was awarded damages in a medical negligence claim involving post-operative infection associated with surgical mesh used in incisional hernia repair. Mr Baran submits the case involved extensive expert evidence about the potential risks associated with mesh repairs, which Dr Tran tended to downplay.

97. I do not agree with Mr Baran's submission that I would give Dr Tran's opinion no weight. He is clearly experienced in his field, and he had the benefit of having treated Mr Eve over some time. However, I agree that the tone and language of his reports dated 12 August 2019 and 15 June 2020 in particular suggest a lack of objectivity. It was not necessary to refer to Dr Garvey's "so-called expertise" and the "so-called conjoint tendon repair" and it was not necessary or even relevant to attach a "Google review" from one dissatisfied individual.

98. In my view, the apparent lack of objectivity in Dr Tran's reports undermines the weight they should be given.

99. Associate Prof Myers agrees with Dr Tran that the proposed surgery has little prospect of success although he does not agree that it carries the "life-threatening" risks foreshadowed by Dr Tran. In contrast to Dr Tran's, Associate Prof Myers' reports are careful and considered.

100. Dr Endrey-Walder's reports are also careful and considered, and he supports the exploratory surgery. He was not convinced that conjoint tendon repair was necessary but said exploration of the medical end of the inguinal canal and the scrotum would be reasonable. Moreover, he said, Mr Eve's "abject symptomatology and functional deficit" for more than three years, and that nothing else promises to make any difference to his condition, was reason to support Dr Garvey's proposal.

101. Dr Garvey did not say that conjoint tendon repair is necessary, as Dr Tran suggests. He specifically stated that it was difficult to say whether the conjoint tendon was involved because of Mr Eve's pain but it might appear so during exploratory surgery. He acknowledged Mr Eve's is a difficult case and said surgery is not recommended lightly, but he remained of the view it was Mr Eve's best chance of relieving his pain and returning to work. He gave his reasons for disagreeing with Dr Tran that referral to an orthopaedic surgeon was needed.

102. Mr Eve has had injections, painkilling medications, hydrotherapy and physiotherapy, and his symptoms persist. Dr Tran recommends "expert pain management with neuromodulation with medications, physiotherapy, psychotherapy, rehabilitation, skill retraining and other potential neurosurgical interventions." He said targeted nerve injections may also help. He said he was aware of "other treatment modalities" but he had no experience with them.

103. In my view, Dr Tran does not come to grips with Mr Eve's assertion that medications have failed to relieve his pain and the fact that Associate Prof Myers thought they would not change any underlying issues. However, Dr Tran sees a role for expert pain management, which is Dr Brooker's field.

104. Dr Brooker is not a surgeon and acknowledges that he cannot comment on the proposed surgery itself. Nevertheless, he says, as a pain specialist he has a role in advocating for appropriate surgery. He supports Dr Garvey's proposal.

105. In my view, Dr Garvey's reports give clear and detailed reasons for proposing what he acknowledges is complicated surgery. He is an experienced surgeon. He acknowledges the proposed surgery is not without risks and has no guarantee of success. I accept his opinion that, in all the circumstances, it is Mr Eve's best chance of relieving his pain and returning to work. I prefer Dr Garvey's opinion to that of Dr Tran.

106. There is no suggestion that the cost of the proposed surgery is not reasonable.

CONCLUSION

107. Mr Eve's evidence is that he has not had sustained relief from medications or injections, hydrotherapy or physiotherapy. He sees a psychologist. He is not yet 40. Apart from about two months in 2019, he has not worked for three years. I am satisfied that the exploratory surgery proposed by Dr Garvey offers a reasonable chance of ameliorating his pain and allowing him to return to work. I am satisfied that it is reasonably necessary surgery for the purposes of s 60.