WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: 6777/19
Applicant: Craig Twyford
Respondent: Woolworths Group Limited
Date of Determination: 23 March 2020
Citation: [2020] NSWWCC 86

The Commission determines:

1. The respondent is to pay the costs of and incidental to the surgery proposed by Dr Bhisham Singh (page 44 of the Application to Resolve a Dispute).

2. The costs incurred for that treatment are reasonably necessary for the injury the applicant sustained in the employment of the respondent on 25 April 2010.

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

Elizabeth Beilby

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 E BEILBY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

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Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Craig Twyford (the applicant) commenced employment with Woolworths Ltd (the respondent) in 2005. He was hired as a team manager working at Wyong. His employment predominantly involved picking boxes as instructed on a set of headphones. The applicant says that on any given day there would be a significant amount of pulling, lifting and pushing hundreds of boxes of various weights.

2. On 25 April 2010, the applicant was lifting a box of broccoli from the rear of the pallet and felt a sharp pain to the right side of his neck, shoulder, right arm and upper back area. He says that this injury was sustained after five years of lifting heavy boxes.

3. The applicant then went to see the onsite physiotherapist, as directed by the return to work coordinators from the respondent, Mr David Yager, for treatment. Mr Yager prescribed exercises and restricted work duties for the applicant.

4. The applicant was then referred to Dr Eric Lim (General Practitioner) by the return to work coordinators who he consulted and was prescribed painkillers.

5. The applicant underwent an MRI of his cervical spine on 20 December 2010 which disclosed a C5/6 disc bulge.

6. The applicant returned to work at Wyong undertaking the same picking jobs. He claims he sustained further injuries in September and November 2010 and another incident in February 2011.

7. The applicant then consulted with Dr Ferch[1] (neurosurgeon) in February 2011. Dr Ferch had the benefit of reviewing the MRI scan and confirmed that there was degenerative change at the C5/6 level, with some loss of disc height and focal kyphosis. On examination the applicant presented with a moderate restriction of movement around the neck. It was the doctors view at that time that the neck pain was likely to be related to arthritic change affecting the facet joints in the neck. Surgery was not recommended however Dr Ferch on examination opined that the applicant would benefit from physiotherapy and other conservative treatment

8. The applicant was also referred to Professor Ghabrial in September 2011 who understood that the MRI scanning showed right disc herniation, C5/6 segment without any compression on the neural elements. Dr Gabriel opined the applicant had a disc injury at this level with radiculopathy into the right arm. Fortunately, it seemed that the radiculopathy had settled down so Dr Ghabrial suggested that the applicant should continue with conservative treatment and not lift more than 15 kilograms.

9. When the applicant returned to work and provided his medical certificates to human resources, he says that he was informed by Ms Pam Speers, the return to work coordinator for Woolworths, that he was hired to pick boxes and that is what a team member is expected to do.

10. As a direct result, when the applicant returned to work to undertake work picking boxes, he continued to lift heavy weights and experienced difficulty with the lifting.

11. The applicant says that between 2010 and 2014, he was given suitable duties but these aggravated his pain and the applicant says they were similar to the duties he had before.

[1] Application page 47

12. In 2014, it became apparent that the applicant was not meeting his picking rate resulting in a meeting where his employment was terminated. Following the termination the applicant has had sporadic employment which he says he was unable to sustain due to his pain.

13. The applicant underwent an MRI on 19 April 2017 which showed a right-sided paracentral C5/6 disc bulge and a small central C6/7 disc bulge. There was also slight neural exit foraminal narrowing at C5/6 most severe on the left as described. In particular, at C6/7 the small central disc bulge was noted as slightly indenting the thecal sac.

14. The applicant underwent a further MRI of the cervical spine on 14 January 2019 at which time there was no cord compression found. There was mild spondylitic changes manifesting as varying degrees of disc space narrowing and posterior fibro-osseous bar formation most pronounced at C5/6 and C6/7. A potential for neural compromise was not identified.

15. The applicant was referred to Dr Bhisham Singh (Neurosurgeon). The first consultation took place in February 2019.[2] Dr Singh, after multiple consultations recommended the surgery as sought in this application.

EVIDENCE

Documentary Evidence

16. 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, and

    (b) Reply to Application to Resolve a Dispute.

ISSUES FOR DETERMINATION

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

    (a) Is the proposed surgery reasonably necessary?

18. An issue that may arise after the determination of this claim is whether section 59A of the 1987 Act applies. That is, whether there are artificial aids used in an anterior cervical decompression and fusion. The parties agreed that this is a matter that can be hopefully agreed upon following this determination.

PROCEDURE BEFORE THE COMMISSION

19. The parties attended an Arbitration on 21 February 2020. 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.

Oral Evidence

20. There was no application to adduce oral evidence.

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[2] Application page 39.

Medical Evidence

21. I will now consider the medical evidence and opinion in the filed documents.

22. The surgeon who recommended the surgical treatment is Dr Singh. On his first consultation, Dr Singh understood that the applicant had significant neck and arm pain from a long standing disc herniation at C5/6, with additional disc bulging at C6/7. Dr Singh considered that conservative treatment had been tried and failed and that an Anterior Cervical Decompression and Fusion from C5-7 was appropriate.

23. In a consultation on 7 March 2019, Dr Singh took a history of bilateral arm pain which the doctor thought arose from disc bulging and foraminal stenosis at C5 to C7.

24. In a further consultation on 25 June 2009, Dr Singh once again took a history of persistent neck pain radiating into both arms and once again recommended surgery.

25. Dr Singh has prepared a thorough report outlining his opinion, treatment undertaken and surgical recommendations dated 10 September 2019[3]. Dr Singh took a history of the applicant having C5/6 disc bulging from 2009 with the symptomatology now becoming more significant and a recent MRI revealing that he has a C6/7 disc bulge. Dr Singh wishes to perform surgery on the applicant arising from a longstanding disc herniation at C5/6 and disc bulging at C6/7. Dr Singh notes the applicant had tried and failed conservative treatment and the surgical option to be considered would be an anterior cervical decompression and fusion at C5-C7. He also suggests a trial of a right C5/6 foraminal injection for diagnostic and therapeutic purposes.

26. Dr Singh linked the applicant's cervical condition to the work stacking boxes in a warehouse in his thorough and informative report. He noted that on examination the applicant has neck and periscapular pain with radicular symptoms into the arms, the right arm being worse affected. He noted the MRI scan recently and a previous one in 2009 [sic, 2010] which revealed that the applicant has disc bulging in the cervical spine at C5/6 and C6/7 which to the doctor's mind were responsible for the symptoms.

27. Dr Singh has had the opportunity of reading the medical opinion of Dr Breit who suggested that neurophysiological studies of the upper arm may be of use. Dr Singh agrees that this would improve the accuracy of the diagnosis however because the applicant continued to have significant difficulty in performing activities of daily living for the past several years and because of the failed conservative treatment, it was reasonable for the applicant to consider the surgical option. Dr Singh quite clearly thought that the MRI scan of 9 January 2019 which revealed disc bulging at C6/7 and C5/6 would be likely contributing to the applicant's symptoms and as such surgery should involve both those levels. (Essentially this is in disagreement with Dr Breit who thought that there was no neurological impingement.)

28. The applicant was referred to Dr Bodel by his solicitors. Dr Bodel has prepared a report dated 27 September 2019[4]. Dr Bodel described the applicant's injuries as being injuries to the neck, right shoulder, upper part of the back and referred pain to the right arm.

29. Dr Bodel understood that the MRI scan of the cervical spine on 20 December 2010 displayed a significant C5/6 disc prolapse and that the applicant had experienced extensive conservative care with rest, analgesic medication and physiotherapy. Dr Bodel observed the MRI of the cervical spine on 14 January 2019 showed significant disc pathology at C5/6 and C6/7 levels and as such the abnormalities there indicated that the surgical procedure was reasonably necessary.

30. On examination, Dr Bodel found tenderness in the trapezius muscles on the right-hand side with reduced range of neck flexion particularly on the left.

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[3] Application page 43
[4] Application page 19

31. Dr Bodel opined that the applicant had suffered an injury to his neck with right shoulder and arm pain and C6 nerve root signs in the right upper limb as a result of the original injury that occurred at work on 25 April 2010, an injury from which the applicant has never fully recovered. Dr Bodel diagnosed the applicant as having a disc prolapse at C5/6 and C6/7 and he may have had rotator cuff pathology in the region of the right shoulder but there was no clinical sign at the time of the examination.

32. Dr Bodel clearly stated that the applicant needed to consider operative treatment and that the anterior cervical decompression and fusion at C5/6 and C6/7 was reasonably necessary treatment to be considered in the circumstances. Dr Bodel made it clear in his report that the applicant had clinical evidence of nerve root irritability on testing in his examination and it was such in his view that the proposed surgery was reasonably necessary and was a consequence of the workplace injury in April 2010 (together with some impact from the nature and conditions of his employment). Dr Bodel observed the MRI of the cervical spine on 14 January 2019 showed significant disc pathology at C5/6 and C6/7 levels and as such the abnormalities there indicated that the surgical procedure was reasonably necessary.

33. Dr Eric Lim is the applicant's general practitioner who has prepared a report dated 1 September 2010[5]. At that time Dr Lim took a history of an incident on 25 April 2010 where the applicant suffered shoulder and neck pain whilst lifting crates.

34. In a further report dated 1 August 2011, Dr Lim noted that the applicant had gradually resolving neck pain and had some psychological symptomatology. Dr Lim thought the applicant should not lift more than 15kg with a picking limit of four hours with rotation. Dr Lim was of the view that the applicant had suffered a muscular injury resulting in a diagnosis of neck/shoulder muscular strain injury with discopathy.

35. In a further report dated 22 August 2019 from Dr Lim to the applicant's solicitors, Dr Lim refers to the incident on 25 April 2010 which to his mind aggravated underlying changes which had developed from years of physical work. Dr Lim thought the C5/6 disc bulge and the deterioration therein resulted from the workplace employment. Dr Lim disagreed with the opinion of Dr Breit on the basis the applicant had persistent pain and dysfunction over the many years he had looked after him and the symptoms had not resolved.

36. The applicant consulted Dr Ferch, neurosurgeon in February 2011 after being referred to him by his general practitioner Dr Lim. Dr Ferch in his report of 7 February 2011[6] observed the applicant had a moderate restriction of movement of his neck particularly in extension which aggravated his neck pain. Neck movement did not precipitate any neurological symptoms on examination. Dr Ferch was of the view that the neck pain was likely to be related to arthritic change affecting the facet joints. It was suggested that the applicant should improve his stretching exercises program and consult a physiotherapist.

37. The applicant consulted Dr Ghabrial, orthopaedic and spinal surgeon in September 2011. Dr Ghabrial has prepared a report dated 6 September 2011.[7] Dr Ghabrial had the opportunity to consider the MRI scan which had been organised by Dr Ferch which showed right disc herniation at the C5/6 segment without any compression of the neural elements. There was also loss of the cervical lordosis indicative of severe muscle spasm. The applicant at that time was undergoing treatment by way of remedial massage and acupuncture which did give him some relief. Dr Ghabrial was of the view that the applicant's difficulty was a disc injury at the C5/6 segment with radiculopathy into the right arm. The radiculopathy had settled down but the applicant continued with residual neck symptoms and muscle guarding. At that stage Dr Ghabrial did not suggest any cervical intervention.

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[5] Application page 28
[6] Application page 47
[7] Application page 48

38. The applicant was examined by Dr Breit on 11 March 2019. Dr Breit has prepared a report dated 15 March 2019[8]. Dr Breit took a history of injury which was consistent to that which other doctors have taken focusing on an injury on 25 April 2010.

39. The applicant complained to Dr Breit that he had pain in the right side of the trapezius radiating into the neck and to the right shoulder. There was said to be pins and needles and tingling in the right index and middle finger intermittently. On examination, there was tenderness in the right trapezius and there was diminished sensation in the right thumb, index and middle finger only. Dr Breit unfortunately does not record the exact findings on examination of the neck but only the shoulder.

40. Dr Breit also records the findings on the 2010 MRI and the 2019 MRI. Unfortunately he does not seem to have been provided with the 2017 MRI. In respect of the 2019 MRI Dr Breit observes that there was relatively minor degenerative changes and disc osteophyte formation at C5/6 and C7. It was some importance to Dr Breit that there were no findings on the MRI of central or foraminal stenosis and no evidence of impingement.

41. Dr Breit diagnosed the applicant as having an aggravation of a pre-existing cervical spondylosis. The doctor did not think there was any nexus between the nature and conditions of the applicant's employment and causing cervical spondylosis. In respect of the cervical spine, the doctor did consider that the applicant has non-verifiable radicular complaints given that there were sensory changes in the thumb, index and middle finger alone which may be suggestive of carpal tunnel syndrome and not radiculopathy.

42. It was Dr Breit's opinion that because the MRI does not show evidence of either central or foraminal narrowing and there was no evidence of radiculopathy that there was no indication for the surgical intervention. Dr Breit thought that the applicant should have an EMG study first in any event.

FINDINGS AND REASONS

43. Section 60 requires that it is reasonably necessary as a result of the injury that medical or related treatment or hospital treatment be provided. There has been a well-entrenched and well-travelled path by well-learned people considering the expression of 'reasonably necessary'. Burke CCJ considered the expression 'reasonably necessary' in various cases, one of the most informative to my mind is that of *Pelama Pty Ltd v Blake* [1998] NSWCC 6. In that case his Honour appeared to accept the submissions made by counsel as to the appropriate matters to be considered when determining treatment was reasonably necessary. They were appropriateness, alternatives, cost, effectiveness and acceptance by the medical profession.

44. Following Burke CCJ's informative descriptors as to the 'reasonably necessary test' Deputy President Roche has further provided guidance as to the meaning of 'reasonably necessary' in a matter of *Ajay*[9]. On the question of 'reasonably necessary' the Deputy President stated at paragraph 67:

> "Whether any particular treatment is reasonably necessary as a result of an injury must be assessed on a case by case basis with the Commission exercising 'prudence, sound judgement and sense'. It is not solely a matter for statistical analysis, though that will often be relevant. On balance, the Arbitrator concluded that there was a reasonable chance for successful outcome of the proposed surgery and it is better for Mr Yee to have the surgery that to forego it. That conclusion was open on the evidence and discloses no error."

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[8] Page 1 of the Reply

[9] *Ajay Fibreglass Industries Pty Ltd t/as Duraplus Industries v. Yee* [2012] NSWWCCPD 41

45. The applicant's case is essentially that there has been an injury to the cervical spine arising as pleaded. The applicant points to the history provided to many Doctors of a frank injury at work, followed by symptomatology and then pathology on investigation.

46. Dr Ghabrial, who was at that stage, the treating surgeon, observed that there was a herniation of the disc.[10] Following that consultation Dr Ferch also observed degenerative changes which supports a finding that the displayed pathology in the MRI taken shortly after the onset of pain was caused by the pleaded events .

47. Dr Lim was hopeful that the applicant could get back to work at a full capacity[11] and Dr Ghabrial suggested that there should be acupuncture and massage.[12] Dr Ferch indeed in 2011 did not opine that surgery was going to be necessary and suggested the applicant trial alternate treatment.[13] This included physiotherapy, remedial massage and injections. The applicant did continue on and it seems that there was no satisfactory result after many years of various treatments including injections and non-invasive treatment.

48. Dr Bodel is clearly of the opinion that the applicant has significant problems and that surgery is reasonably necessary. He observes radicular symptoms which is consistent with the opinion of Dr Singh.

49. The respondent submitted that there was only minor changes displayed on the magnetic resonance imaging. Essentially it was put that this is a case that is dealing with only minor pathology and surgical treatment is not indicated.

50. The respondent complains that Dr Singh does not address that the radiological reports do not show neural compromise. The respondent complains that Dr Bodel's opinion also suffers from the same problem and indeed he acknowledges that there are small or minor pathology displayed on the MRI.

51. This submission to my mind has limited weight as both Dr Bodel and Dr Singh observe and record radicular symptomatology. I accord, in particular, significant weight to the examinations and observations of Dr Singh, given he is the treating surgeon and has seen the applicant on multiple occasions. He, to my mind, is in the best position to be able to determine the existence of radicular symptoms.

52. The respondent also complains that it appears that the need for surgery is attributed to degenerative change not because of a disc bulge. This however to my mind ignores the onset of symptomatology at the pleaded time. The submission may have had more force if the symptoms existed before the pleaded events or if there was a significant hiatus between the pleaded events, onset of symptoms and the claim now. To the contrary, it is persuasive in my mind that they are all proximate.

53. The respondent says Dr Singh does not appear to have looked at the most recent MRI which does not display a disc bulge. This is not a correct description of Dr Singh's opinion. Quite clearly he is of the view that the applicant does have a disc bulge and it is Dr Singh's opinion that this is contributing to the applicants pain. Dr Singh, had the benefit of his clinical observation and examination. His opinion is also consistent with that of Dr Bodel. I do not find this submission persuasive.

54. By way of summary, in this matter I must have regard to the categories as proposed by his Honour Judge Burke and in doing so exercise prudence, sound judgment and good sense.

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[10] Application page 48
[11] Application page 30
[12] Application page 49
[13] Application page 47

55. So far as appropriateness is concerned, it is only the medical opinion of Dr Breit who has formed the view that the treatment is not appropriate. Both Dr Bodel and the treating surgeon, Dr Singh, have formed the view that the surgery is reasonably necessary. To this end I note that Dr Singh has had the advantage of seeing the applicant on many occasions and his opinion to my mind ought be granted significant weight. To my mind the pathology does on balance show a condition at C5/C6 which does not appear to be idiopathic but has been caused by work.

56. In respect of alternatives, the applicant has already tried non-invasive and conservative treatment to no assistance. There does not appear to me to be any proposed alternative that ought be explored before this surgery save for the suggestion by Dr Breit of further investigation. Dr Breit does not explain what this further investigation will do and why it is necessary. Dr Singh though does say it would help with diagnosis but seems comfortably satisfied as to the requirement for surgery. I am not persuaded that there are any viable alternatives to the proposed surgery.

57. As far as cost is concerned no submissions were made into the cost of the surgery and given the applicant's complaints of pain and symptomatology the cost is not considerable.

58. So far as effectiveness is concerned it is the opinion of both Dr Singh and Dr Bodel that the surgery is likely to be successful. To this end I note that the applicant does not need to prove that the surgery would be definitively successful but only that there is a reasonable chance of a successful outcome from the proposed surgery. To my mind the opinions of Dr Bodel and Dr Singh support such a finding.

59. There is an acceptance by the medical profession as to the utility of surgery such as this and indeed Dr Singh and Dr Bodel both agree and accept that it is appropriate and reasonably necessary the applicant undergo such treatment.

60. Therefore, after considering all the evidence in this case, and bearing in mind the applicant does not need to prove that the surgery will be undeniably successful but rather that he ought to have it than not, and that it is reasonably necessary, I am satisfied the applicant has discharged the burden of proof in relation to the proposed surgery.