WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **5371/20**
Applicant: **Shaun Donnelly**
Respondent: **Camsons Pty Ltd**
Date of Determination: **19 January 2021**
Citation No: **[2021] NSWWCC 19**

The Commission determines:

1. The applicant has not proven that medical cannabis is reasonably necessary as that phrase is used in section 60 of the *Workers Compensation Act 1987*.

2. It is noted that the respondent is to provide to the applicant a 12-month pool pass for hydrotherapy subject to:

    (a) Certification from the applicant's nominated treating doctor as to the required treatments and attendances; and

    (b) The provision by the applicant of the sign-in records or other evidence verifying his attendance at the pool.

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

Paul Sweeney
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 Paul Sweeney, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

INTRODUCTION

1. The only remaining issue in this matter is a claim for a trial of medical cannabis as part of a pain management program. Shaun Donnelly (the applicant) seeks orders that a trial is reasonably necessary in accordance with section 60 of the *Workers Compensation Act 1987* (the 1987 Act) and that Camsons Pty Ltd (the respondent) pay the cost of such treatment.

2. The need for treatment by medical cannabis is alleged to result from an injury to the applicant's left shoulder on 25 February 2013, when he fell from a ladder while washing trucks. It is common ground that the injury occurred in circumstances entitling the applicant to compensation. The respondent's workers compensation insurer has paid the applicant compensation in accordance with sections 36, 37 and 38 of the 1987 Act. It has also paid the cost of extensive medical treatment performed or directed by medical practitioners for the purpose of ameliorating the condition of his left shoulder.

3. Dr Kuo, an orthopaedic surgeon, undertook arthroscopic surgery on the applicant's left shoulder on 3 July 2013 and 15 June 2016. The first surgical procedure appears to have been undertaken to repair the labrum. The second operative procedure, while performed arthroscopically, appears to be more extensive involving debridement of the glenohumeral joint, subacromial decompression and biceps tenodesis.

4. The applicant has also been treated by two pain management specialists Dr Henry Lam and, more recently, Dr Tilman Boesel. Those doctors have treated the applicant with a variety of pain management techniques, including nerve blocks of the left shoulder and opioid medication without any obvious improvement in his condition.

5. Dr Boesel recommended that the applicant be seen by Dr Ho, another pain specialist in his practice, for a consideration of a trial of medical cannabis. The respondent disputes that this treatment is reasonably necessary based on the opinion expressed in a report of Dr David Gorman, a pain specialist, dated 17 January 2020.

PROCEDURE BEFORE THE COMMISSION

6. By these proceedings, the applicant also claimed the cost of a 12-month pool pass to enable him to undertake hydrotherapy and permanent impairment compensation in respect of the injury to his left shoulder and a consequential medical condition of his neck.

7. When the matter came on for a telephone conference on 18 October 2020, I was informed by the parties that they had reached agreement on the issue of a pool pass by which the respondent would pay the cost on certain conditions. The claim for permanent impairment compensation involved a medical dispute. By consent, it was remitted to the Registrar for referral to an Approved Medical Specialist to certify the degree of permanent impairment, if any, in respect of the applicant's left shoulder and neck.

8. As the parties were certain that the claim for the cost of medical cannabis could not be the subject of an agreement, I set the matter down for conciliation and arbitration in November 2020. Unfortunately, because of an oversight the matter was not listed for conciliation and arbitration on the appointed day. Rather than standing the matter over to another conciliation and arbitration date, the parties suggested that the matter be determined after written submissions by counsel retained for each party. Those submissions have been lodged in accordance with my direction.

EVIDENCE

9. The documents before the Commission are as follows:

    (a) The Application to Resolve a Dispute and the documents attached, and

    (b) The Reply and the documents attached.

10. There was no objection to any of the material referred to above. There was no application to adduce further evidence.

SUBMISSIONS

11. The submissions of counsel are almost entirely concerned with the arguments and opinions of Dr Ho, the applicant's pain specialist and Dr Gorman, the pain specialist retained by the respondent. In those circumstances, I propose to compendiously set out the primary arguments of both doctors before referring to the submissions of counsel. First, however, I recite the salient aspects of the applicant's evidence.

Applicant

12. The applicant's evidence is contained in a series of signed statements. As a good deal of the content of those statements is of historical interest only, it is unnecessary to reiterate it for the purposes of these reasons. The applicant is 29 years of age. In his initial statement, dated 21 October 2015, he provides a brief account of his injury. He says that he was washing a truck up a ladder when "the ladder slipped, and I injured my left shoulder when I fell."

13. The applicant consulted his general practitioner Dr Graydon and after the failure of conservative treatment was referred to Dr Kuo, the shoulder surgeon, who performed arthroscopic surgery on his left shoulder at Nepean Private Hospital on 3 July 2013. The applicant states:

> "I have been told I will never get back to the type of work that I was doing before. I have continued to have significant problems with my shoulder and I have been back to see Dr Kuo who has recommended that he do further surgery on my left shoulder."

14. The applicant states that he has also seen Dr Geoffrey Hughes, a shoulder specialist, who also recommended that he undergo further arthroscopic surgery with a view to establishing a diagnosis.

15. In 2015, the applicant continued to experience significant symptoms in his left shoulder. He underwent a series of cortisone injections which also failed to provide relief. In July 2016, Dr Kuo performed the second arthroscopic procedure at Nepean Private Hospital.

16. By a statement of 1 August 2019, the applicant says that following the surgery on 3 July 2013, he attended physiotherapy and hydrotherapy. Neither the initial surgery performed by Dr Kuo or the physiotherapy were beneficial. The applicant says:

> "At that time my symptoms did not improve much after the surgery and perhaps even became worse."

17. In 2016 or 2017, the applicant recounts that he was referred to Professor Boesel, a pain specialist who performed a nerve block on his left shoulder under a general anaesthetic. The applicant states that the 2016 surgery "didn't help at all with my symptoms".

18. Following the failure of surgery, the applicant was treated with pain relief medications. These included “nerve specific medications” and opioids. The applicant states:

> “I have found that some of these medications were too strong and would cause me significant side effects and did not help with the pain. As a result, the medications that I have been prescribed have regularly been changed.”

19. The applicant also recounts that he has seen a physiotherapist at the request of Professor Boesel, Jane Bradshaw, and has been treated by a clinical psychologist. He states that:

> “Dr Kuo and Professor Boesel have told me that there is nothing further that they can do to assist me, and there is no further surgery that they can offer me.”

20. The applicant says that following the injury on 25 February 2013 he performed light duties until the surgery in 2013. Approximately two months after the surgery, he returned to office work, which he continued to perform. In 2016, he was certified totally unfit for work as both Dr Kuo and his general practitioner “thought that work was too much for me”.

21. The applicant says that he does not think he would be able to perform his work at Camsons. He gives the following account of his symptoms:

> “I have chronic pain in my left shoulder. It is very strong pain and keeps me awake at night. My movement is restricted in my left shoulder and I have changes in sensation in my shoulder. Some areas of my shoulder can be extremely sensitive and just touching them can cause strong pain.
>
> The pain moves back across the back of my shoulder and down my upper back and left arm all the way to my hand. I have various symptoms in my left arm and hand including pain, changes in sensation, decreased strength and decreased ranges of movement. I have difficulty using my left hand and drop things on some occasions. In my left arm and hand, I get tingling and hot and cold and sweaty sensations.”

22. The applicant states that he has pain and soreness in his neck and “changes to the range of movement in my neck”. He says that he is prepared to do anything to relieve the pain. He says that he is unhappy using opioids as he does not wish to become addicted to the drugs. He states that he has trouble doing the simplest of things and the “pain effects everything that I do”. Accordingly, he wishes to undertake the trial of cannabis oil suggested by Dr Boesel.

Dr David Gorman

23. Dr Gorman saw the applicant on 6 January 2020 and provided a report dated 17 January 2020. He obtained a detailed history of the applicant’s treatment including his treatment with Lyrica, Targin and Maxigesic. He also recorded that the applicant had pain in his left shoulder which radiated down the arm, to the biceps and scapular, and up to the left side of his neck. He was not working, and “simple movements” exacerbated the pain.

24. The doctor expressed the opinion that cannabis therapy was not appropriate in this case. He attached to his report a position paper from the ANZCA Faculty of Pain Medicine and other papers from medical journals in support of his contention. He opined that:

> “There is no evidence that the use of medical cannabis will reduce his opioid consumption. It may improve sleep and may reduce anxiety but I do not believe there will be any significant improvement in pain or function and no reduction in opioid use.”

25. Dr Gorman also believed the use of medical cannabis would impede the applicant's rehabilitation. Driving would not be possible while taking cannabis and he would be prohibited from working on some job sites. He noted that medical cannabis can cause hallucination and sedation and stated that some of the long-term effects of medical cannabis included vehicle crashes, cognitive impairment, structural brain changes and psychotic symptoms. He expressed the opinion that addiction to opioids may be "magnified by the addition of medical cannabis".

26. As an alternative to medical cannabis, Dr Gorman expressed the opinion that self-management, including a great focus on aerobic exercise would be of value. He observed that occupational rehabilitation was important as it would be unfortunate if attempts were not made to find the applicant suitable light work at 28 years of age. He concluded:

> "Focus on medical cannabis treatment will take away the focus on better forms of rehabilitation. His clinical problem is a difficult one – when signs of complex regional pain syndrome arise in an upper limb after shoulder injury, the outcomes can be poor. However, medical cannabis is not the answer and further nonpharmacological attempts at rehabilitation should be the focus."

Dr Ho

27. Dr Ho saw the applicant on 8 June 2020 and provided a report of 8 July 2020. Dr Ho also recorded a consistent history of treatment. He noted that the applicant had significant restrictions on his activities of daily living in that he required assistance with home maintenance tasks and only retained modified independence in the areas of personal care and driving. After examining the applicant, he diagnosed a chronic pain syndrome which was either chronic nociplastic or neuropathic left upper extremity pain secondary to central sensitisation.

28. Dr Ho expressed the opinion that the applicant's capacity to work was likely to improve with a multi-disciplinary pain program focusing on desensitisation and functional drill. His prognosis for the future was guarded. He stated:

> "In my opinion, Mr Donnelly's prognosis with pain and further improvement is guarded given his ongoing pain severity and chronicity, as well as the persistent pain-related disability. I opine that his chronic pain is likely to fluctuate but unlikely to further progress or worsen."

29. In addition to a multi-disciplinary pain management program with a chronic pain team, Dr Ho expressed an opinion in respect of the use of cannabis oil. He said this:

> "The clinical decision for a CBD oil trial is made on a case-by-case basis. I note it is not common practice for the treatment of chronic pain at this stage. The trial is based upon a personalised medicine principle and not a population of evidence-based medicine principle. I further note that there is poor scientific evidence for the efficacy or safety of CBD oil at this stage."

30. Nonetheless Dr Ho thought that the use of CBD oil was significantly less harmful than the use of opioids and that a trial was appropriate if the patient had "failed other more conservative and more evidence-based medication/s." He thought a specific program limited to three months with "meaningful" goals should be implemented. If those goals were not achieved, the trial should be terminated. He also referred to the TGA guidance in respect of medical cannabis. Further, he recommended a psychologist's clearance to rule out any contra indications for the use of cannabis and that the trial would only be an "adjunct" with self-management strategies.

31. By a report of 6 August 2020, Dr Gorman responded to Dr Ho's report. He agreed with Dr Ho that focus on a multi-disciplinary pain management program with self-management of pain, desensitisation and functional improvement was important. He remained wary of adding a potentially addictive medication to the current treatment regime for a relatively young man. Most concerning was the "unknown effects of long-term cannabis use". He continued:

> "Perhaps most importantly, addition of a further medication would take away the focus on self-management – the best cognitive behavioural approaches always focus on the use of self-management techniques rather than reliance on pharmacological techniques. The addition of further pharmacological technique essentially contradicts the concept of self-management in a multi-disciplinary pain management program."

SUBMISSIONS

32. As the submissions of counsel are in writing, I do not propose to reiterate the submissions in these short reasons. I set out below the main thrust of counsel's arguments.

33. Mr Stockley, who represented the applicant, argued that as Dr Ho and Dr Gorman agreed on "the current state of scientific and medical assessments regarding the effectiveness of medical cannabis" it was unnecessary for the Commission to attempt to reconcile a difference of scientific opinion. He argued that in deciding the matter I should focus on whether "Dr Ho's personalised medicine principle is accepted as an appropriate approach to the proposed trial" of cannabis.

34. Mr Stockley noted three factors which militated in favour of Dr Ho's approach. First, the refractory nature of the applicant's condition which had persisted and spread since 25 February 2013. Secondly, the fact that there was no history of drug or alcohol abuse and, lastly the fact that the "supervised pain management program" had not provided a satisfactory outcome.

35. Mr Stockley emphasised the fact that the medical reports demonstrate that the applicant had had trouble in managing his sleep. He observed that Dr Gorman accepted that the use of medical cannabis may improve sleep and improve anxiety. He argued that "this alone justifies the making of an order in his favour".

36. He submitted that the assessment required an evaluative process undertaken by the application of the authorities on the question of "reasonably necessary" to the circumstances of the case: *Diab v NRMA* [2014] NSWWCCPD 719 at 76 and 91.

37. In performing that evaluative process, it was important to bear in mind that Dr Ho's opinion was not an "open-ended prescription for administration of a drug". He merely suggested a trial with well-defined goals. The applicant submitted that this was a cautious approach and "should allay the concerns of Dr Gorman regarding dependence and addiction".

38. Mr Robertson also referred to *Diab* and submitted that the trial of medical cannabis did not meet the criteria set out in that case. He observed that Dr Boesel had expressed the view in May 2019 that further medical therapies, including drugs and blocks "probably won't help if escalated".

39. Mr Robertson then referred to Dr Boesel's clinical record in which he noted some reduction in the use of opiates while the applicant underwent treatment hydrotherapy and psychological treatment in 2019 and 2020. He argued that the reduction in the use of opioids with these treatments established a viable alternative to the use of cannabis oil.

40. Mr Robertson argued that Dr Gorman's opinion was supported by the position paper of the Faculty of Pain Medicine, Australia, and New Zealand College of Anaesthetists, which Dr Gorman attached to his report. He noted there was agreement between the medical practitioners as to the value of a multi-disciplinary pain management program. He noted that such a program was previously recommended by Dr Lam in 2014 but "did not eventuate" for reasons that are not clear. He continued:

> "There is plainly controversy in relation to the use of medical cannabis in this case. The respondent submits that given the purpose of the pain management program, it ought to have been undertaken prior to the consideration of any medical cannabis trials."

41. In respect of effectiveness of treatment, Mr Robertson referred to the lack scientific evidence for the efficacy or safety of CBD oil. He submitted that it presently did not have a place in the usual armoury of treatments utilised by pain specialists for the applicant's condition.

42. Mr Robertson addressed Mr Stockley's submission that the Commission should favour the "personalised medicine principle" evoked by Dr Ho and stated:

> "That does not do justice to Dr Gorman's opinion which plainly does involves assessment of the Applicant as well as consideration of the criteria required for determination of what is reasonably necessary treatment including appropriateness, alternatives, effectiveness and acceptance by medical experts. Plainly his opinion is informed to some extent by the science as well as the views of "pain specialists where there is not widespread support at all".

DISCUSSION AND FINDINGS

43. The parties accept that the matter is to be determined by reference to the principles set out by Deputy President Roche in *Diab.* In applying the instruction of the Court of Appeal in *Clampett v WorkCover Authority (NSW)* (2003) NSWCCR 99, *Diab* significantly modified the "standard test adopted in determining if medical treatment is reasonably necessary as a result of a work injury" formulated by Burke CCJ in *Rose v Health Commission (NSW)* 1986 2 NSWCCR 32 (*Rose*).

44. While the matters set out in *Rose* as the criteria of reasonableness are "useful heads for consideration" the "central question remains whether the treatment was reasonably necessary". Further, "reasonably" supported a lesser requirement than "necessary". "Depending on the circumstances, a range of different treatments may qualify as reasonably necessary" and a worker must only establish that the treatment claimed is one of those treatments. A worker certainly does not have to establish that the treatment is "reasonable and necessary", which is a significantly more demanding test that many insurers and doctors apply."

45. The cases referred to in Diab also unequivocally establish that novelty is not a basis for rejection of proposed treatment and that entitlement is not limited to the ordinary forms of treatment generally prescribed by the medical profession for treatment of a particular condition.

46. It is unnecessary to examine the history of the case in detail as the submissions of the parties have largely addressed the present. My impression, however, is that the applicant's condition has progressively worsened with the passage of time.

47. Before and after his initial surgery, he was able to work in a selected duties capacity. Following surgery in 2016, the applicant has not returned to employment. He told Dr Breit, on 16 December 2019, that despite physiotherapy and hydrotherapy his shoulder "remained worse than it was prior to the second operation". Subsequently, the applicant reported that the suprascapular nerve block performed by Dr Boesel "made the shoulder worse".

48. In his report of 12 February 2020, Dr Breit observed that there had been a significant reduction in movement of the applicant's left shoulder between 2018 and December 2019 although he could find "no apparent reason for that to have occurred". Similarly, Dr Anderson, the applicant's qualified occupational physician, who last saw him on 1 June 2020, recorded that the range of movement of his cervical spine was less than on his previous examination in September 2019, although the finding in respect of left upper limb remained the same.

49. In 2020, Dr Anderson observed "gross restriction of movement of the left shoulder". Thus, there is only an equivocal evidentiary basis for Mr Robertson's submission that the applicant's condition was improving during the latter period of his treatment by Professor Boesel. Rather, the histories suggest some long-term worsening of the applicant's complaint of pain and restriction of movement in his left shoulder and neck.

50. Dr Ho and Dr Gorman suggest that the applicant commence a multi-disciplinary pain management program. This may be a more sophisticated version of the treatment prescribed by Dr Lam, a pain specialist, between 2014 and 2015, which the doctor referred to as an integrated Multi-Disciplinary Pain Management Work-Related Activity Treatment. That treatment was not successful. Obviously, since the applicant undertook that treatment, further surgery has been carried out by Dr Kuo.

51. It is probable that the applicant is addicted to opioids, which have been prescribed by Dr Boesel for several years. Certainly, this is the view of Dr Grayson, the applicant's general practitioner. The records of the Western Sydney Pain Centre suggest that significant progress has been made to reduce the prescribed dosage. But it is not clear that the applicant has successfully come off opioids. Each of the medical practitioners in this case suggest that is the most desirable outcome, although it is difficult both physically and psychologically for the applicant to achieve.

52. Dr Ho prefaces his recommendation that the applicant undertake a trial of CBD oil by noting that it is not common practice for the treatment of chronic pain at present. As Mr Stockley submitted, he based his recommendation on a "personalised medical principle". Dr Ho stated:

> "I further note that there is poor scientific evidence for the efficacy or *safety* of CBD oil at this stage." (my italics)

53. It is true that Dr Ho is concerned that there be regular clinical assessment by a pain specialist to ensure safety and efficacy. Initially, he contemplates a trial for three months. This cautious approach is in keeping with TGA guidance which states:

> "In the absence of strong evidence for dosing and specific preparations of cannabis or cannabinoids in the treatment of CNCP, it is recommended that any treating physician who elects to initiate cannabinoid therapy should assess response to treatment, effectiveness and adverse effects after one month. This is best achieved as part of a research project or clinical audit."

54. There remains, however, the necessity to balance efficacy and safety. It is undisputed that there are risks associated with the use of medical cannabis. They include addiction, psychotic symptoms, structural brain changes, and cognitive impairment. I assume that such risks would be minimised by a short trial of medical cannabis. Nonetheless, I am unable to understand why the applicant should be subjected to these risks, however minimal, when there is no compelling evidence that the treatment proposed will be efficacious.

55. Dr Ho does not put forward a convincing case that medical cannabis will assist the applicant in opioid withdrawal or that it will lessen his experience of pain. Dr Gorman, on the other hand, expresses the opinion that either outcome is improbable. It is accepted that medical cannabis might assist with the anxiety and sleep. But there are other modes of treatment which can address these problems.

56. The applicant has been treated with a variety of medication, including several opioids, over many years. It is of fundamental importance, as I understand the medical evidence, that he be weaned off harmful medication. The optimal outcome is that the applicant can ultimately self-manage his pain, with assistance of less harmful analgesia. In those circumstances, I believe there is considerable force in Dr Gorman's opinion that prescribing a potentially addictive new medicine at this stage will diminish the focus on the difficult process of withdrawal from the opioid treatment regime.

57. Finally, there is the fact that the applicant will be excluded from driving and from attending job sites during his treatment. While this is the least important of the reasons for rejecting the proposed trial of medical cannabis, it augments the other arguments deployed by Dr Gorman. It is important, as he opines, that the applicant be offered the opportunity for some selected employment at the earliest possible time. He has remained out of the workforce for five years. Experience suggests that if that situation is not remedied shortly, the applicant will join the ranks of the long term unemployed.

58. In my opinion, the evidence does not demonstrate that the treatment proposed by Dr Ho, namely CBD oil is reasonably necessary. The evidence does not establish benefit, other than the likelihood that it may improve the applicant's sleep. On the other hand, there are significant risks which are poorly understood. In those circumstances, it is inappropriate to subject the applicant to those risks.

59. My impression is that the applicant has been exposed to undue risk by his past treatment regime. It is difficult to understand why he was treated with opioids over such a long period, when the addictive and debilitating qualities of these drugs has been known to medical practitioners for many years. I do not believe that it is appropriate to magnify these risks . It is, of course, possible that further trials will reveal greater benefits from the use of medical marijuana than are presently proven. At that time, an analysis of the benefits of efficacy and safety may produce a different outcome.

60. I have determined the case largely by reference to the applicant's history and circumstances rather than the research attached to Dr Gorman's report. The statement from the Faculty of Pain Medicine (FPM) of the Australian and New Zealand College of Anaesthetists is, however, consistent with the outcome. It includes the following:

> "FPM is very concerned about the adverse event profile in cannabis users, especially in young people, including impaired respiratory function, psychotic symptoms and disorders and cognitive impairment.
>
> At the present time, the scientific evidence for the efficacy of cannabinoids in the management of people with chronic non--cancer pain is insufficient to justify endorsement of the clinical use.
>
> FPM recognises the difficulties inherent in performing trials of any medications in patients with chronic non-cancer pain. Nonetheless FPM believes that if pragmatic trials of cannabinoids are considered to be necessary, they should be conducted on a coordinated national basis."

61. In accordance with the agreement of parties, I note that the respondent is to provide to the applicant a 12-month pool pass for hydrotherapy subject to:

    (a) Certification from the applicant's nominated treating doctor as to the required treatments and attendances; and

    (b) The provision by the applicant of the sign-in records or other evidence verifying his attendance at the pool.