WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **740/20**
Applicant: **Tracy Elaine McMillan**
Respondent: **Budage Pty Ltd**
Date of Determination: **28 May 2020**
Citation: **[2020] NSWWCC 178**

The Commission determines:

1. The applicant has not discharged the onus of establishing on the balance of probabilities that the surgery proposed by Dr Anil Nair is reasonably necessary as a result of the injury on 25 June 1997.

2. Award for the respondent.

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

Rachel Homan
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 RACHEL HOMAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Ms Tracy Elaine McMillan (née Smith) (the applicant) was employed by Budage Pty Ltd (the respondent) as a word processor operator. On 25 June 1997, the applicant sustained an injury to her lumbar spine when she slipped on a tiled area after stepping off an escalator. Liability for the injury was accepted by the respondent's insurer.

2. In September 2019, the applicant requested approval to undergo a L4/5 and L5/S1 anterior lateral interbody fusion surgery, as proposed by Dr Anil Nair. Liability for the surgery was declined in a notice issued pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act), dated 10 December 2019.

3. On 12 February 2020, the applicant lodged an Application to Resolve a Dispute (ARD) seeking compensation for the proposed surgery pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act).

ISSUES FOR DETERMINATION

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

    (a) Whether the surgery proposed by Dr Nair is reasonably necessary as a result of the injury on 25 June 1997.

PROCEDURE BEFORE THE COMMISSION

5. The parties appeared for conciliation conference and arbitration hearing conducted by telephone on 4 May 2020. The applicant was represented by Mr William Carney of counsel, instructed by Mr Douglas Eggins. The respondent was represented by Mr Marco Nesbeth of counsel, instructed by Mr Neil Bennett.

6. 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

7. The following documents were in evidence before the Commission and taken into account in making this determination:

    (a) ARD and attached documents;

    (b) Reply and attached documents.[1]

8. Neither party applied to adduce oral evidence or cross-examine any witness.

[1] No objection for the purposes of cl 44 of the *Workers Compensation Regulations 2016* was taken by the applicant in relation to the forensic reports attached to the Reply on the basis that they were included for the histories taken in relation to previous claims for compensation.

Applicant's evidence

9. The applicant's evidence is set out in a written statement made by her on 20 December 2019. The applicant stated that she was employed by the respondent between September 1994 and October 2001.

10. On 25 June 1997, the applicant was travelling to work when she slipped on a tiled area on the concourse at Circular Quay train station after stepping off an escalator. The applicant fell and landed on her hands and knees, jarring her hips, knees and lumbar spine.

11. The applicant started physiotherapy and began wearing a back brace in around December 1997.

12. On 20 August 1998, the applicant tripped and jarred her back again when she stepped out of a lift which had stopped about a foot short of the floor. The applicant was prescribed Naprosyn and Mersyndol Forte and continued with physiotherapy.

13. The applicant's back flared up again in around 2000 after the birth of her second child, causing her legs to give out. The applicant fell and broke her wrist.

14. In around 2005, the applicant moved to Wodonga and began seeing Dr Terence Hillier at Alpine Orthosport. On 28 March 2007, the applicant underwent a discogram and CT scan. On 4 April 2007, Dr Hillier recommended a disc replacement and spinal fusion surgery, approval for which was declined by the insurer.

15. On 14 December 2007, the applicant underwent surgery to have a trial spinal cord stimulator implanted with approval from the insurer. The trial was a success and it was decided that a permanent spinal cord stimulator would be implanted. That procedure was performed on 7 March 2008.

16. After the permanent spinal cord stimulator was implanted, the applicant found she had relief for approximately six weeks at a time before she had to go in for reprogramming. This happened every six weeks until the applicant moved to Darwin in June 2008.

17. On 18 September 2009, the applicant underwent surgery to have the spinal cord stimulator repositioned to improve stimulation. The applicant still got only about six weeks' benefit before needing reprogramming. From that time onwards, the applicant went to Sydney once a year for reprogramming.

18. On 24 April 2015, the applicant underwent surgery to remove the spinal cord stimulator. The applicant's pain levels increased following an attempt to increase the hours she was working.

19. In March 2016, the applicant's legs gave out causing her to fall and exacerbate her back pain. The applicant's doctors trialled her on a new medication, Jurnista, but it did not agree with the applicant. The applicant was unable to continue working.

20. In January 2019, the applicant consulted a neurosurgeon, Dr Efendy, who referred her to a chronic pain specialist. The applicant no longer wished to be on medication due to serious side-effects. The applicant stopped taking all heavy medications and managed her pain with physiotherapy, hydrotherapy, Panadol and ibuprofen.

21. On 1 August 2019, the applicant saw Dr Hillier again and was advised that she was still an ideal candidate for an anterior disc replacement and spinal fusion, especially as the rest of her spine was in excellent condition. Dr Hillier wanted the applicant to meet with his colleague, Dr Anil Nair for his opinion.

22. On 26 October 2019, the applicant met with Dr Nair who was confident in the success of the surgery but wanted to have an updated discogram to compare with the 2007 discogram. Dr Nair considered this would give a lot more detail than ordinary MRI scan and stated that the most recent MRI showed a nerve cluster at the surgical site of the spinal cord stimulator. The insurer declined to pay the costs of Dr Nair's appointment or treatment.

23. The applicant said she suffered chronic lumbar pain affecting her right leg constantly and left leg on exacerbation. The applicant experienced a range of other symptoms including weakness in her lower extremities, lack of balance and her legs giving way.

Evidence from the applicant's treating doctors

24. An MRI of the applicant's lumbar spine performed on 22 March 2002 was reported to show:

> "There is decreased signal intensity on T2 weighting in the L4/5 and L5/S1 discs indicating disc dehydration and degeneration.
>
> At the L4/5 level, there is a small left lateral disc protrusion encroaching on the proximal portion of the left neural exit foramen but without encroachment on the left L4 nerve root.
>
> At the L5/S1 level, there is a small right postero-lateral and lateral disc protrusion, but without encroachment on the theca or neural structures.
> …
> There is no evidence of canal stenosis."

25. Orthopaedic surgeon, Dr Terence Hillier saw the applicant on 19 December 2006. Dr Hillier took a history of the injuries in 1997 and 1998 and said the applicant remained troubled with lumbar pain which had waxed and waned over the years but had gradually become more constant and severe. The applicant was using a walking stick for support when her pain was severe and relied on a flexible lumbar brace. Dr Hillier said his clinical impression was that of discogenic pain but considered an updated MRI and discogram were appropriate.

26. An MRI performed at Dr Hillier's request on 11 January 2007 was reported to show mild disc dehydration at L4 - S1. There were minor central posterior disc bulges at L2/3, L3/4 and L4/5 as well as a small disc bulge in the left exit foramen at L4/5. There was no central canal exit foraminal stenosis at any level.

27. On 21 February 2007, Dr Hillier reported,

> "The clinical impression is very much that of disc pain and an updated MRI, with weight bearing images, does confirm that her spine does remain very healthy above L4 and at L4-L5 there are only minor disc changes. This tends to focus on the darkened and flattened L5-S1 disc which may well have internal disruption and develop discogenic pain and in view of her still struggling to cope I have suggested that it wold be worthwhile at least verifying this with investigation in the form of two level lumbar discography…"

28. A discogram was performed on 28 March 2007, the report of which revealed:

> "L4/5: This level was abnormal with bilateral posterior lateral radial tears with contrast extending to the outer annular fibres. These radial tears appear more extensive on the left compared to the right side. On injection the patient's baseline pain became a little worse in a similar distribution to the usual symptoms (lower back and right leg).

L5/S1: This disc appears more degenerate than the level above with loss of disc height particularly posteriorly. With injection of contrast there is significant right posterolateral radial tear in the region of the right nerve root canal with extravasation into the adjacent soft tissue outlining the L5 nerve root primally. A posterior annular tear extends posterior early and also postero-laterally to the left outlining the outer annular fibres.

…
On injection of this level radiating pain down both legs was reported (rated 7/10) – more severe than the L4/5 level."

29. On 4 April 2007, Dr Hillier noted in correspondence to the applicant that she had found the discogram procedure painful to recover from and that it showed "quite extensive disc damage and pain at both the discs tested". Dr Hillier advised:

> "As I have explained, it certainly remains safe to cope with this if you feel that you can manage, but taking up your point that you are struggling to cope, I did outline what would be involved in a hybrid management of this and that is, carrying out a spinal fusion with a locked cage at L5 – S1 and a disc replacement at the L4 – L5 level."

30. Dr Hillier described the procedure and outlined the risks associated with it.

31. Dr Hillier prepared a report for the insurer on 12 April 2007. Dr Hillier noted the extensive conservative treatment the applicant had undergone at that point in time:

> "She had a 2 year program of physiotherapy supervised spinal exercises and she has also had other forms of conservative treatment which included analgesic medication.
>
> She has worsened over time.
>
> I have not instituted any further conservative treatment given her failure to gain with extensive programs of treatment and the fact that her pain has become more intense. She uses a walking stick to mobilise her and has become increasingly distressed with significant lumbar pain.
>
> As explained, the outcomes of treatment that has occurred over an extended period, which has been based on non-surgical treatment, has not only been ineffective but it also has seen her condition deteriorate."

32. Dr Hillier confirmed that there were no signs of neurological abnormality but said there was internal disruption of the lumbar discs at L4/5 and L5/S1. Dr Hillier explained the basis on which he considered surgery was indicated:

> "The current indicator for surgery is her increasing lumbar discomfort. In addition, the fact that she has not been able to achieve any benefit with the extensive conservative treatment over a long period and, in particular, a committed 2 years of exercises under physiotherapy supervision.
>
> The surgery is based on confirmation that the L4-L5 and L5-SI discs have distinct signal change on MRI indicative of internal disc disruption and discography has confirmed that both discs are symptomatic.
>
> The surgery has been proposed to endeavour to address this discogenic pain."

33. Dr Hillier said the anticipated functional benefits of the surgery would include significant settling of her current discogenic pain and becoming more independent.

34. Dr Hillier prepared a further report for the applicant's solicitor on 9 July 2007, which he reiterated the opinions described in his earlier reports.

35. A report to the insurer from pain medicine specialist, Dr Henry Lam, dated 27 September 2007 noted that the applicant had minimal pain coping strategies or pain management skills and would benefit significantly from an integrated multidisciplinary pain management program.

36. On 31 October 2007, Dr Lam recommended a trial spinal cord stimulator. Dr Lam later reported that the trial spinal cord stimulator had given the applicant substantial pain relief and allowed her to increase her functional capacity and decrease her pharmacotherapy. On 28 February 2008, Dr Lam recommended the applicant undergo insertion of a permanent spinal cord stimulator.

37. On 11 September 2009, Dr Lam reported that the applicant had a poor response to the stimulator. The applicant was booked for repositioning of the spinal cord stimulator. On 27 November 2009, Dr Lam reported that the repositioning of the spinal cord stimulator had improved things. The applicant was undergoing massage, Pilates, hydrotherapy and physiotherapy.

38. On 9 June 2011, neurosurgeon and spine surgeon, Dr James van Gelder reported that the applicant continued to complain of predominantly mechanical lower back pain and could experience loss of control of her right leg. Dr van Gelder noted the applicant was very tender in the lower back. Dr van Gelder advised:

> "Symptoms are consistent with chronic mechanical back pain associated with moderate intervertebral disc degenerative changes that have previously been shown at L4/5 and L5/S1. She does not have a clear cut indication for further investigations or spinal interventions or surgical procedures at the present and is best managed using pain medicine approaches. Having said that, spinal surgery such as an anterior lumbar fusion as has been discussed with her before as a treatment option for disabling degenerative back pain for highly selective patients. These issues were discussed with Mrs Smith. I will be happy to review her in the future if it would be helpful but no specific appointments have been made."

39. On 7 September 2012, Dr Lam reported that the applicant was having major problems, in particular, pain across her thoracic region and hip and pain radiating down her left and right legs.

40. On 13 March 2015, Dr Lam requested approval for the applicant to undergo removal of the permanent spinal cord stimulator.

41. The report of an MRI performed on 7 August 2015 noted mild degenerative change of the discs at L4/5, L5/S1 but without canal or foraminal compromise. Similar findings were noted in the report of an MRI performed on 5 April 2017. Degenerative lower lumbar discs were noted again in an MRI report on 12 October 2018.

42. There are in evidence a large number of reports prepared by Dr Gavin Chin, consultant in rehabilitation and pain management. These reports demonstrate complaints of persisting pain and record a number of trials of different conservative approaches and pharmacotherapy. In a report dated 10 November 2015, Dr Chin reported to the applicant's general practitioner:

> "Her MRI only showed mild degenerative changes at L4/5 and L5/S 1. There was no neural compromise. This was quite a significant finding from my point of view. I believe that she has central sensitisation and fear of pain. I could not explain the cause of her right leg pain."

43. Dr Chin considered that the applicant needed to continue a multimodal approach to manage her pain.

44. A different specialist in pain medicine, Dr Jason Kwon wrote to the applicant's general practitioner on 27 April 2016 in relation to the applicant's chronic low back pain radiating to both legs. Dr Kwon reported:

> "In the past she went through our pain management programme. She also had a spinal cord stimulator implanted in 2008. Unfortunately the spinal cord stimulator did not work well and it was removed in 2015.
>
> For last few months she has been having exacerbation of lower back pain. She described the pain as constant dull ache with sharp exacerbation with activities up to 8/10 intensity with radicular pain going down both legs. Recent MRI scan of lumbar spine performed in August 2015. It showed mild degenerative changes are at L4/5 and L5/S 1 discs without evidence of neuronal compromise.
>
> Due to ongoing pain she has been feeling depressed. She sleeps poorly at night. She is unable to do most of the housework and cannot drive a car. She had been working, doing community services until April this year, however due to exacerbation of pain, and she had to give up the work."

45. Dr Kwon concluded that the applicant was suffering from ongoing lower back pain and radicular pain without any clear evidence of pathology shown on MRI scan. He considered the applicant's pain was mainly due to soft tissue injury. Dr Kwon said,

> "Significant pain sensitisation has developed as evidenced by severe allodynia and hyperalgesia."

46. Interventional Pain Management Specialist, Dr Paul Ferris reported on 22 February 2017 that he recommended a range of treatments including:

> "psychotherapy, dietitian for weight reduction programme, bariatric surgery, tempur bed, hydrotherapy and further trial for a spinal cord stimulator."

47. A Darwin-based neurosurgeon, Dr Johnny Efendy, wrote a letter of referral to Sydney-based neurosurgeon Dr Simon McKechnie on 27 May 2019 requesting an opinion with regard to the applicant's management. Dr Efendy noted that the applicant had been treated conservatively with pain relief. Dr Efendy noted that the applicant had previously seen Dr Hillier who had suggested that because of the disc desiccation at L4/5 and L5/S1, the applicant would need spinal fusion at both these levels. Dr Efendy had noted the risks involved with any spinal surgery and requested Dr McKechnie's input as to whether fusion would help with the applicant's pain.

48. Dr Hillier prepared a report for the applicant's general practitioner on 1 August 2019. Dr Hillier noted that over the previous 12 years the applicant had continued to be troubled and had no benefit from a spinal cord stimulator which had now been removed. Dr Hillier said the applicant presented as a highly motivated person with clear clinical features of discogenic pain which was distressing and disabling. Dr Hillier said,

> "The latest MRI of April this year confirms that she remains structurally very sound in all the rest of her lumbar spine but the lower two discs still have height maintained but are clearly still provoking her pattern of discogenic pain.

> I feel that she still represents an ideal candidate for an approach through the abdomen, avoiding any need to disturb her previous surgical approach for the spinal cord stimulator, and clearance of those discs as a pain generator and then stabilisation with again either a hybrid or a two-level fusion."

49. Spinal surgeon Dr Anil Nair wrote to the insurer requesting approval for a request approval for a L4/5 & LS/51 anterior lateral interbody fusion surgery on 12 September 2019. The request was not accompanied by any report justifying the procedure.

50. Dr Nair provided handwritten responses to a series of questions from the insurer dated 16 September 2019. Dr Nair indicated there were no identified non-compensable factors impacting the applicant's pathology. Dr Nair described the expected functional gains following surgery as "improved sitting, standing and work tolerances and function". Dr Nair was asked whether the surgery would likely to result in further surgery. Dr Nair responded,

> "Highly unlikely an anterior lumbar surgery in a young cohort has been shown not to be associated with significant risk of adjacent segment pathology."

Dr Stenning

51. The respondent relies on a medicolegal report prepared by Dr Warwick Stenning, neurosurgeon, dated 26 November 2019. Dr Stenning took a history broadly consistent with the other evidence.

52. Dr Stenning performed an examination and reported,

> "Lumbar spine movements were all restricted to approximately one half of the normal ranges. There was patchy reduction of pinprick sensation in both legs, chiefly in the inner aspect of the left thigh and inner aspect of the right foot."

53. Dr Stenning said the applicant showed him a number of investigations including MRIs performed in 2000 to 2007, 2015 and 2017; the lumbar CT discogram, performed on 28 March 2007; CT scans performed in 1998, 2009 and 2010; and SPECT/CT scans performed in August 2018 and July 2019 which showed no abnormal uptake of tracer in the lumbar spine.

54. Dr Stenning said he had also reviewed a number of reports some of which are not in evidence before the Commission in these proceedings. These included:

> "A report by Mr M Sharland, orthopaedic surgeon, dated 6 September 2018, stated that the plaintiff had had a right L4/5 facet joint injection two weeks previously, which had led to complete relief of her pain. He referred her for an opinion regarding a possible L4/5 fusion.
> …
> A report by Dr Michael Biggs, neurosurgeon, dated 20 June 2019, was the result of the Telehealth consultation. He advised against surgery."

55. Dr Stenning noted that there had been no progression on the status of the L4/5 and L5/S1 disc since the MRI performed in 2002. On this basis, Dr Stenning concluded,

> "The most likely diagnosis is a chronic pain syndrome, although I would concede that I am not an expert in the diagnosis of this condition. However, I can state that I cannot find a strong connection between her radiological appearances and her current symptomatology."

56. With regard to the appropriateness of the recommended surgery, Dr Stenning gave the opinion:

> "There is insufficient evidence, in my view, to justify the recommendation of a lumbar fusion. Of particular importance is the lack of abnormal tracer uptake in a number of SPECT/CTs, up to the most recent which was performed on 18 July 2019.
>
> It has been my clinical experience that when a SPECT/CT is strongly positive, that a lumbar fusion has a good chance of relieving the pain. However, when it is negative, the chances of the fusion relieving the pain would fall well below 50%.
>
> In my view, the risks of such surgery are not outweighed by the potential benefits."

57. Asked whether the treatment recommended was required as a result of the workplace injury, Dr Stenning responded,

> "I have doubts as to whether the spinal fusion is required as a result of the workplace injury for reasons outlined in answers to previous questions. However, I accept that the compensation process has, in fact, accepted that the back injury was the result of the workplace incident in 1997. This, in my opinion, applies to the chronic pain syndrome, and not the purported degenerative conditions in the spine."

Respondent's historical expert reports

58. Attached to the Reply are a number of expert reports procured by the respondent in relation to previous claims.

59. An orthopaedic surgeon, Dr John P H Stephen reported to the insurer on 20 May 2013. Dr Stephen took a history that included:

> "She moved to Albury in 2006 with her family. There she saw an orthopaedic surgeon, Dr Terrence Hillier, who arranged for an MRI scan and then a discogram. He recommended surgery but following a second opinion obtained by a neurosurgeon, Dr Michael Feamside, who had significant reservations about the proposed fusion, the operation never did go ahead."

60. Dr Stephen's examination showed "quite good" range of lumbar movement and so sensory loss or reflex abnormality in the lower limbs. Dr Stephen considered a range of investigations including the 2007 discogram. Dr Stephen diagnosed:

> "Ms Smith has a chronic pain syndrome. There is no evidence of any radiculopathy but she has quite severe levels of pain in the presence of only mild to moderate degenerative change."

61. Orthopaedic surgeon, Dr John Walsh, reported to the insurer on 28 April 2016. Dr Walsh said he had viewed a number of reports included those referred to above as well as some which are not in evidence including, a report from neurosurgeon, Dr Fearnside, and a letter from orthopaedic surgeon, Dr Bentivoglio.

62. Dr Walsh indicated that Dr Bentivoglio had formed the opinion in 1998 that the applicant did not have enough symptoms to benefit from any surgical treatment. Dr Walsh noted that Dr Fearnside had considered Dr Hillier's reports and expressed the view in 2007 that:

> "…he had great concerns, that this procedure is appropriate for Ms Smith. Lumbar discography is not a good indicator of outcome following spinal surgery. She has all of Waddell's signs present which are adverse prognostic fact indicators .... The contraindication to Ms Smith undergoing the proposed surgery is the longevity of the symptoms (10 years) in the presence of chronic pain behaviour…"

63. Dr Walsh recorded restricted movements and tenderness over the whole of the lumbar spine and thoracic spine on examination. Dr Walsh considered a number of investigations including the 2007 discogram. Dr Walsh expressed the view:

> "I consider the changes noted on the various investigations she has had, including the more recent MRI scan of her cervical spine to be age related rather than as a consequence of the falls.
> …
> I note there has been a psychological reaction to her pain, with various specialists referring to chronic pain syndrome and the presence of positive signs indicating this in 2007 in the report from Dr Feamside.
> …
> On examination today, there was even an exaggerated response, particularly when attempting to rotate her hips with the knees bent, which does not have any effect on the spine at all but which brought her to tears…"

64. Dr Walsh made a diagnosis of chronic pain syndrome and sick role syndrome. Dr Walsh considered that no further treatment was indicated other than an exercise program and weight reduction. Dr Walsh said,

> "I agree with Dr Fearnside that surgery would have had an adverse effect if it had been carried out and should be avoided now."

65. Another orthopaedic surgeon, Dr Thomas Silva prepared a report for the respondent on 20 February 2017. Dr Silva noted in his examination:

> "There were significant pain behaviour features during the rest of the clinical examination, especially with straight leg raising and in the execution of active lumbar spine movement."

Dr Bodel

66. A Medical Assessment Certificate was prepared by Dr James Bodel in previous Commission proceedings following exam on 5 December 2003. Dr Bodel noted at the time that the applicant was being treated with simple analgesic medication and gentle exercise. The applicant had intermittent hydrotherapy and physiotherapy and had tried acupuncture. The applicant had been seen by Dr Bentivoglio, an orthopaedic surgeon who had discussed the possibility of surgery but had not recommended this to the applicant. The applicant complained of constant pain in the back, both hips and right leg pain.

67. Dr Bodel found;

> "Ms Smith has suffered an injury to the back in the form of a disc injury at L4/5 and L5/S1. Clinically this has mainly arisen as a result of the original injury on 25 June 1997 but there is a further small contribution to her ongoing complaints as a result of the subsequent injury on 20 August 1998."

68. Dr Bodel said the applicant had genuine mechanical symptoms in the back associated with the disc pathology seen on the MRI scan.

Applicant's submissions

69. Mr Carney noted that the injury in this case was relatively old, having occurred in 1997. Liability for the injury had been the subject of determinations by the Commission and the injury was the subject of a Medical Assessment Certificate by Dr Bodel.

70. Mr Carney took me to the history of the injury set out in the applicant's statement and her evidence of the treatment she received over the years. Mr Carney noted that the applicant had undergone extensive conservative treatment including implantation of a spinal cord stimulator. The applicant had in recent times seen a neurologist, pain specialist and then returned to orthopaedic surgeon Dr Hillier. Dr Hillier had proposed surgery and had done so since 2007.

71. Mr Carney submitted that the applicant's pain had been chronic for a long period of time. Although the radiological investigations did not suggest an acute protrusion and some doctors would be hesitant to recommend surgery, Dr Hillier had consistently advocated surgery for this applicant and was the main mover for the surgery.

72. Mr Carney noted Dr Hillier's report that the applicant's pain had waxed and waned over the years but had by 2006 become more constant and severe. Dr Hillier noted the applicant to be using a walking stick and considered the applicant had discogenic pain localised to the bottom two segments of the lumbar spine. As the applicant was struggling to cope, she underwent a discogram in 2007, following which Dr Hillier proposed surgery.

73. Mr Carney noted the difference between the procedure proposed by Dr Hillier in 2007 and that now proposed by Dr Nair. Dr Hillier had however provided an opinion in support of Dr Nair's proposed surgery.

74. Mr Carney submitted that Dr Hillier had consulted with the applicant over a substantial period of time, well over a decade, and had viewed the available scans. Although the scans did not reveal a lot of structural damage, and there was no acute protrusion indenting the thecal sac or nerves, Dr Hillier remained of the view that the surgery was reasonably necessary. Dr Hillier was the doctor who had seen the applicant the most and had requested the scans. Dr Hillier expressed the view, on the basis of the discogram, that there was internal derangement. Dr Nair was also willing to proceed to surgery. Mr Carney referred me to the opinions given by Dr Nair.

75. Mr Carney noted the report of Dr van Gelder. Mr Carney submitted that Dr van Gelder agreed that the applicant had chronic mechanical back pain at the L4/5/S1 levels, which was best managed using pain medication. Dr van Gelder's report noted that a fusion procedure had been discussed and said this was a treatment option for disabling pain in select patients. Mr Carney submitted that this opinion was consistent with the view that the surgery proposed was appropriate in extreme cases like the applicant's case.

76. Mr Carney noted that a different opinion had been expressed by Dr Stenning but submitted that Dr Stenning seemed to accept that there was an injured disc. There had been no progression since the MRI in 2002. Although Dr Stenning was doubtful that the injury was causative of the applicant's current pain, he did not address the probability that there was internal discal damage as found on the discogram. Dr Stenning had not reviewed the discogram in 2007 or if he did, he did not comment on it. Mr Carney noted that it was the discogram that led Dr Hillier to the view that surgery was required. Mr Carney noted that Dr Bodel had considered the discogram for the purposes of providing a Medical Assessment Certificate. On this basis, Mr Carney submitted that I would prefer the opinions of Dr Hillier and Dr Nair.

77. Mr Carney noted that funding for an updated discogram had not been approved and it had not been pursued given the lack of change shown on the other investigations.

78. Mr Carney described this as a singular case in so far as the applicant had symptoms and disabilities dating from 1997. The applicant had not rushed into surgery. The applicant had undergone vast amounts of conservative treatment with numerous doctors over the years. The alternative treatments provided no improvement in functionality or her tolerances. Consistent with the authorities in *Diab v NRMA Ltd*[2] and *Rose v Health Commission (NSW)*[3], Mr Carney submitted there should be a finding that the surgery is reasonably necessary.

Respondent's submissions

79. Mr Nesbeth submitted that the applicant relied heavily on Dr Hillier but Dr Hillier deferred to Dr Nair as he was not qualified to conduct the proposed surgery. Dr Nair had not provided an opinion addressing the relevant issues, namely the appropriateness of the surgery, the availability of alternatives and the potential effectiveness of the surgery. The answers given by Dr Nair to the insurer fell short of what was required and was insufficient to establish that the proposed surgery was reasonably necessary medical treatment.

80. Mr Nesbeth noted that the applicant referred to Dr Nair examining the applicant on 26 October 2019, at which time he indicated that he would like to have an updated discogram to compare with that taken in 2007. Mr Nesbeth said there was no evidence that Dr Nair was confident in proceeding with surgery in the absence of an updated discogram. The previous discogram was in 2007.

81. Mr Nesbeth said there was no clear evidence of a worsening of symptoms or changes in the radiological investigations. The latest MRI appeared to suggest the applicant's lumbar spine was structurally sound at all levels other than the lower two and that height was maintained at those levels. Mr Nesbeth said Dr Hillier was making an assumption as to the source of the applicant's pain and that matter was contentious.

82. Mr Nesbeth said Dr Stenning was more qualified to speak to this issue and ought to be preferred. He had diagnosed a musculoligamentous strain of which there had been no progression. Mr Nesbeth submitted that this raised a question what was being addressed by the proposed surgery and why. Mr Nesbeth submitted that Dr Stenning found no strong connection between the radiology and symptomology. Dr Nair was silent on these issues.

83. Mr Nesbeth noted that Dr Stenning gave the opinion that there was insufficient evidence to justify the surgery. There was lack of abnormal tracer uptake in the SPECT CT scans. The chance of the applicant's pain improving was well below 50%. The risks accompanying the surgery would not be outweighed by the potential benefits. Mr Nesbeth submitted that Dr Hillier had not addressed these concerns in his reports.

84. Mr Nesbeth said Dr Stenning's view found support elsewhere. Dr Kwon had on 27 April 2006 expressed the view that the applicant's pain was mainly due to soft tissue injury and pain sensitisation. Dr Walsh in April 2016 expressed no doubt that psychosocial factors were a major factor to the applicant's presentation. Mr Nesbeth noted that Dr Ferris addressed the effect of the applicant's anxiety, depression, catastrophisation and weight management.

85. Mr Nesbeth said the picture was more complicated than Dr Hillier appeared to appreciate. Mr Nesbeth said the weight of evidence went against the surgery being reasonably necessary. It was far from clear why Dr Nair endorsed the surgery and considered it reasonably necessary.

[2] [2014] NSWWCCPD 72.
[3] [1986] NSWCC 2; (1986) 2 NSWCCR 32.

FINDINGS AND REASONS

86. Section 9 of the 1987 Act provides that a worker who has received an 'injury' shall receive compensation from the worker's employer in accordance with the Act.

87. 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)."

88. In *Diab v NRMA Ltd*[4] Roche DP, referring to the decision in *Rose v Health Commission (NSW)*[5], set out the test for determining if medical treatment is reasonably necessary as a result of a work injury:

> "The standard test adopted in determining if medical treatment is reasonably necessary as a result of a work injury is that stated by Burke CCJ in *Rose v Health Commission (NSW)* [1986] NSWCC 2; (1986) 2 NSWCCR 32 (*Rose*) where his Honour said, at 48A—C:
> …
>
> 3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.
>
> 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.'"

89. The Deputy President also noted that the Commission has generally referred to and applied the decision of Burke CCJ in *Bartolo v Western Sydney Area Health Service*[6]:

> "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."

[4] [2014] NSWWCCPD 72.
[5] [1986] NSWCC 2; (1986) 2 NSWCCR 32.
[6] [1997] NSWCC 1; 14 NSWCCR 233.

90. Deputy President Roche found:

> "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."

91. It is not in dispute that the applicant sustained an injury to her lumbar spine on 25 June 1997. What requires determination is whether the surgery proposed by Dr Nair is reasonably necessary as a result of that injury.

92. An unusual feature of this case is the lack of detailed explanation from Dr Nair as to the basis on which he has recommended the surgery proposed. The only evidence from Dr Nair, who is the surgeon proposing to perform the procedure. is his request for approval dated in September 2019 and a brief series of answers to questions posed by the respondent's insurer.

93. It may be inferred from the request for approval for the surgery that Dr Nair considered the surgery he proposed to be causally related to the applicant's injury, although that opinion is not explicitly stated. Dr Nair indicated in his responses to the insurer's questions that he had not identified any "non-compensable factors impacting the applicant's pathology". There is, however, no explanation or reasoning to explain Dr Nair's opinion or his understanding of what might be considered "non-compensable factors".

94. Dr Nair has given the opinion that he expected the applicant to have improved sitting, standing and work tolerances and function as a result of the surgery. There is also an opinion from Dr Nair that he considered there was not a significant risk of adjacent segment pathology requiring further surgery.

95. I accept, however, Mr Nesbeth's submission that the evidence from Dr Nair fails to address many of the considerations ordinarily taken into account in determining whether proposed medical treatment is reasonably necessary as a result of a work injury. There is no indication in the evidence before me as to the history provided to Dr Nair, the investigations he considered, the other medical evidence he considered, whether he examined the applicant, or his findings on examination, if there was one.

96. Dr Nair has not explained why he considered purpose and potential effect of the surgery was to alleviate the consequences of injury. There is no explanation as to why the treatment is considered appropriate. Dr Nair does not explain whether there is any other alternative treatment or whether that would be potentially effective. Whilst Dr Nair has identified some expected functional improvements, he has not given an opinion as to the likelihood of those improvements being realised.

97. Another barrier to accepting Dr Nair's proposal for surgery is that it predates an apparent consultation in October 2019 described by the applicant in her own statement. The applicant has given evidence that she consulted Dr Nair on 26 October 2019, being a date after the request for approval and after he prepared responses for the insurer. The applicant's evidence is that on that occasion, Dr Nair wanted to have an updated discogram to compare with the 2007 discogram. The applicant also refers to Dr Nair observing that the most recent MRI showed a nerve cluster at the surgical site of the spinal cord stimulator.

98. Mr Carney submitted that the applicant had not undergone a further discogram due to funding not being approved and in the absence of any other evidence of a change or deterioration in the pathology in the applicant's spine. There is no evidence from Dr Nair as to whether he remained of the view that the surgery was appropriate despite the absence of a further discogram. Nor is there evidence from Dr Nair as to anything else discussed at that consultation or any previous consultation.

99. On the evidence of Dr Nair alone, I would not be satisfied that the surgery proposed by him is reasonably necessary as a result of the work injury. There is, however, evidence from another treating specialist, Dr Hillier in support of surgery.

100. Dr Hillier, whilst not proposing to perform the surgery, has given an opinion in support of surgery of the kind proposed by Dr Nair. It appears from a quotation for surgery in evidence that it is proposed that Dr Hillier would assist Dr Nair in performing the procedure.

101. Dr Hillier has had the benefit of seeing the applicant over a period of time. Dr Hillier had recommended surgery and prepared a series of reports in support of surgery in 2007. The procedure now being proposed is different to that recommended by Dr Hillier in 2007. Dr Hillier's report of 1 August 2019 was also given prior to the applicant's consultation with Dr Nair. In his August 2019 report, Dr Hillier did, however, state that the applicant remained an ideal candidate for surgery involving clearance of the two lower discs and stabilisation with either a hybrid or a two-level fusion.

102. Dr Hillier did not state whether he had conducted a clinical examination of the applicant in August 2019. Given the passage of more than 12 years since he last saw the applicant, the extensive conservative treatment undergone in that time, and the nature of the pathology shown on the recent radiological investigations, it seems a further clinical examination would have been appropriate before surgery was again recommended. Dr Hillier's letter is, however, silent on the matter other than to say that the applicant had clear clinical features of discogenic pain. Dr Hillier said the lower two discs were still provoking the applicant's pattern of discogenic pain but did not explain the basis for this opinion. He had noted that recent MRI results showed that the lower two discs had height maintained.

103. I accept that it is appropriate to read Dr Hillier's reports together in order to obtain a clearer view as to the basis for his opinion. Dr Hillier's 2007 reports confirmed that the applicant had been clinically examined. Dr Hillier found that the applicant forward flexed in a limited fashion and had marked spinal dysrhythmia in her muscles on standing from that position to the normal standing stance.

104. Dr Hillier did not immediately recommend surgery in 2007 but ordered further investigations including the lumbar discograms performed on 28 March 2007. On the basis of those results, Dr Hillier formed the view that there was internal disruption of the lumbar discs at the L4/5 and L5/S1 levels causing pain.

105. Dr Hillier was aware of the range of conservative treatments trialled by the applicant both prior to his first consultation with the applicant on 19 December 2006 and in the period between 2007 and 2019. Dr Hillier did not in his most recent report, however, engage with the significant body of evidence suggesting a psychological element to the applicant's experience of pain or the development of pain sensitisation. In contrast to that evidence,

Dr Hillier found the applicant to be “highly motivated” and a “well mentally balanced person who clearly understands her problem”.

106. The applicant has not qualified an independent expert to provide a forensic medical opinion on her behalf for the purposes of this claim.

107. There is an independent opinion set out in a Medical Assessment Certificate from Approved Medical Specialist, Dr James Bodel, dated in 2003. Dr Bodel expressed an opinion, consistent with that later given by Dr Hillier, that there was a disc injury at L4/5 and L5/1 and that the applicant had genuine mechanical symptoms in her back associated with the disc pathology seen on the MRI scan.

108. Dr van Gelder also found the applicant to have symptoms consistent with chronic mechanical back pain associated with moderate intervertebral disc degenerative changes at L4/5 and L5/S1.

109. On the basis of the evidence of Dr Hillier, Dr van Gelder and Dr Bodel and the radiological investigations before me I do accept that the applicant has disc pathology at L4/5 and L5/S1. I also accept that that pathology has been found to be symptomatic. Those findings are not enough, however, to establish that the surgery proposed at the present time is reasonably necessary treatment for the injury.

110. The evidence before me indicates that the applicant has seen a number of specialists in the years since her injury who have considered but not supported surgical treatment.

111. Dr van Gelder in 2011 found that the applicant did not have a clear cut indication for surgical intervention at the time of his report and was best managed using pain medicine approaches. Dr van Gelder did note that surgery of the kind now being proposed had been discussed with the applicant as a treatment option for disabling degenerative back pain for highly selective patients and said he would be happy to review her in the future. The opinion given by Dr van Gelder falls short, however, of an opinion that surgery is now reasonably necessary.

112. The material in the ARD includes a letter of referral from Dr Efendy who noted the previous recommendations of Dr Hillier but sought the opinion of Dr McKechnie as to whether the proposed surgery would assist the applicant. There is no evidence that the applicant consulted Dr McKechnie. I do not consider that this letter from Dr Efendy assists the applicant. At best it shows that Dr Efendy was uncertain as to whether the surgery was reasonably necessary.

113. Dr Stenning reported that the applicant had been treated by an orthopaedic surgeon, Dr Sharland, in September 2018, who had referred the applicant for an opinion regarding a possible L4/5 fusion. There is no evidence from Dr Sharland before me and it is not apparent to whom the referral for an opinion was made. Dr Stenning did also note, however, a report from neurosurgeon Dr Michael Biggs in June 2019 advising against the surgery.

114. Although I do not have evidence from them directly, there is reference in the materials to the applicant having previously been examined by neurosurgeons Dr Bentivoglio and Dr Fearnside. Dr Walsh indicated that he had considered reports from both doctors. Dr Walsh said Dr Bentivoglio had formed the opinion in 1998 that the applicant did not have enough symptoms to benefit from any surgical treatment. Dr Walsh said that Dr Fearnside had considered Dr Hillier’s reports and expressed concern that the procedure was inappropriate for the applicant.

115. Dr Stenning has, after examining the applicant and reviewing an extensive range of radiological investigations and reports from the doctors involved in the applicant’s case, given the view that there is insufficient evidence to justify the recommendation of a lumbar fusion. Although Mr Carney submitted that Dr Stenning did not have the 2007 discogram or if

he did, he did not comment on it, Dr Stenning does state that those investigations did form part of the material he considered.

116. I am satisfied that Dr Stenning had a sufficiently complete history as to provide a proper basis for the acceptance of his opinion. Although noting that he was not qualified to give an opinion that the applicant had a chronic pain syndrome, his impression appears to be consistent with the views expressed by some of the pain specialists involved in the applicant's case and the other experts qualified previously by the respondent. Dr Walsh and Dr Stephen both made a diagnosis of chronic pain syndrome. Dr Silva observed there was significant pain behaviour during his examination.

117. The applicant has undergone extensive pain management treatment for her symptoms. There are a large number of reports in evidence from Dr Lam, Dr Chin, Dr Kwon and Dr Ferris. Both Dr Chin and Dr Kwon considered that the applicant had developed significant pain sensitisation. Dr Kwon found evidence of severe allodynia and hyperalgesia. The pain specialists seemed to consider a multi-modal approach to the applicant's symptoms remained appropriate. Dr Ferris, most recently, has explicitly identified a range of alternative treatments he considered appropriate including, psychotherapy, a weight reduction programme, bariatric surgery, tempur bed, hydrotherapy and further trial for a spinal cord stimulator.

118. After carefully assessing the evidence before me, I accept that the applicant has been found to have pain associated with pathology at the L4/5 and L5/S1 levels, caused by the injury. I accept that the applicant has attempted to address her pain through extensive conservative treatment during the 22 years since her injury. I accept that those attempts have ultimately been unsuccessful. I also accept that Dr Hillier and Dr Nair have formed the view that the surgery recommended by them is appropriate treatment for the applicant's condition.

119. There is, however, a significant body of evidence indicating that the surgery is not appropriate treatment for the applicant. I am satisfied that there are alternative treatments available to the applicant, having regard to Dr Ferris' report. There is little evidence from Dr Nair and Dr Hillier as to the actual or potential effectiveness of the surgery they have propsed. I am not satisfied on the evidence before me that there is general acceptance by other medical experts that the surgery is appropriate and likely to be effective.

120. The cost of the surgery has not been raised as an issue in this case.

121. I accept that all surgical treatment involves risk. It is not necessary that the applicant establish that the surgery has a good or greater than 50% chance of improving her condition. The fact that other specialists disagree with the approach proposed by Dr Nair and Dr Hillier does not mean the treatment is not reasonably necessary. I accept that the applicant has not rushed into a decision to attempt surgery. I accept that the applicant's circumstances are singular in light of the duration of her symptoms and the alternative treatments attempted. There is, however, insufficient evidence from Dr Nair and Dr Hillier to satisfy me that the proposed surgery is reasonably necessary treatment in the context of the other evidence before me.

122. Whilst examinations may have been performed by Dr Hillier and Dr Nair at the time of their 2019 reports, they have not described them or their particular findings, or explained why their examinations support their approach. I am not satisfied that Dr Hillier's findings on examination 13 years ago provide a sufficient basis on which to justify surgery now. It is not clear that Drs Hillier and Nair have considered the full range of evidence put before Dr Stenning. They have not addressed the views expressed by other doctors involved in the applicant's case that she has a chronic pain syndrome and pain sensitisation. They have not clearly explained why the procedure is justified in light of the radiological investigations performed in the last 12-13 years which show only mild pathology that has not changed despite a deterioration in the applicant's functioning. They have not given a clear indication of the potential or actual likelihood of the treatment being effective.

123. It may be that the applicant is able to obtain evidence from Dr Nair and Dr Hillier or an independent expert that would be sufficient to enable her to discharge her evidentiary onus. On the current evidence, however, I am not satisfied on the balance of probabilities that the surgery proposed by Dr Nair is reasonably necessary as a result of the injury.

124. There will be an award for the respondent.

SUMMARY

125. The applicant has not discharged the onus of establishing on the balance of probabilities that the surgery proposed by Dr Nair is reasonably necessary as a result of the injury on 25 June 1997.