WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **51/20**
Applicant: **Alan John Paine**
Respondent: **State of New South Wales (Fire & Rescue NSW)**
Date of Determination: **26 March 2020**
Citation: **[2020] NSWWCC 91**

The Commission determines:

1. The right rotator cuff repair surgery proposed by Associate Professor Haber on 21 June 2018 is reasonably necessary as a result of the injury on 18 April 1999.

The Commission orders:

2. The respondent to pay the costs of and incidental to the right rotator cuff repair surgery proposed by Dr Haber in accordance with s 60 of the *Workers Compensation Act 1987*.

3. The respondent to pay the applicant's costs as agreed or assessed.

A brief 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.

L Golic

Lucy Golic
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Alan John Paine (the applicant) was employed as a firefighter by the State of New South Wales (Fire & Rescue NSW) (the respondent).

2. On 18 April 1999, the applicant sustained an injury to his right shoulder whilst carrying out emergency repairs following a severe hailstorm. Liability for the injury was accepted and compensation paid, including for surgeries to the shoulder performed by Prof George Murrell on 3 April 2001 and 16 November 2004.

3. The applicant now wishes to undergo a right rotator cuff repair surgery as recommended by his orthopaedic surgeon, Assoc Prof Mark Haber.

4. The respondent declined liability for the proposed surgery in dispute notices issued pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) on 31 July 2018 and 6 September 2019.

5. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) filed in the Commission on 8 January 2020.

PROCEDURE BEFORE THE COMMISSION

6. The parties appeared for teleconference on 6 February 2020 and conciliation conference and arbitration hearing on 2 March 2020. The applicant was represented by Mr Paul Stockley of counsel, instructed by Mr John Caristo. The respondent was represented by Mr Andrew Parker of counsel, instructed by Mr Ratna Siva.

7. 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.

ISSUES FOR DETERMINATION

8. The parties agree that the following issue is in dispute and requires determination:

    (a) whether the right rotator cuff repair surgery proposed by Assoc Prof Haber on 21 June 2018 is reasonably necessary as a result of the injury on 18 April 1999.

EVIDENCE

Documentary evidence

9. 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 attachments;
    (c) supplementary report of Dr Yiu Key Ho, dated 30 August 2019, and
    (d) written submissions on costs, dated 3 March 2020.

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

Applicant's evidence

11. The applicant's evidence is set out in a written statement dated 22 December 2019.

12. The applicant stated that on 18 April 1999, he was repairing severely hail damaged roofs at work. Whilst elevating a heavy ladder and repeatedly throwing ropes and tarpaulins over the damaged roofs, the applicant injured his right shoulder. The applicant lodged a claim and the insurer accepted liability for injury to both shoulders and the applicant's neck.

13. The applicant continued to work despite a number of recurrences and flareups of pain until he was medically retired in April 2006.

14. Following the injury, the applicant consulted his general practitioner, Dr Lumbewe. On 8 July 1999, the applicant underwent ultrasounds to both shoulders. The applicant was referred to an orthopaedic specialist, Prof Murrell whom he saw in October 1999. The applicant had an injection to his right shoulder and underwent physiotherapy. Eventually, Prof Murrell recommended right shoulder surgery. On 3 April 2001, Prof Murrell performed acromioplasty surgery, paid for by the insurer. After a course of physiotherapy, the applicant was able to resume full duties.

15. In July 2004, the applicant was referred back to Prof Murrell as his shoulder was getting worse. Prof Murrell recommended a further surgery and, on 16 November 2004, performed a right shoulder capsular release, paid for by the insurer. The applicant was able to resume duties as a firefighter but never fully recovered.

16. In 2005/2006, the applicant underwent another course of physiotherapy and strengthening program and was referred to Dr Goldberg. Dr Goldberg referred the applicant on to a sports physician, Dr Annett and underwent treatment to his left shoulder.

17. The applicant continued to experience symptoms and consulted his general practitioner, Dr Azam on a periodic basis. The applicant took increasing amounts of pain medication as his symptoms gradually worsened. The applicant experienced difficulty sleeping at night because of his right shoulder pain and became very frustrated and stressed about his chronic pain and disability.

18. In December 2017, the applicant had a further scan of his right shoulder and was referred to orthopaedic specialist, Assoc Prof Mark Haber. The applicant saw Assoc Prof Haber on 8 May 2018 and scans and injections were ordered. The injections provided short-term relief.

19. On 5 June 2018, Assoc Prof Haber ordered an MRI of the applicant's right shoulder which was performed on 9 June 2018. Assoc Prof Haber reviewed the MRI results on 21 June 2018. As the applicant had tried physiotherapy, hydrotherapy, medication and injections over many years, Assoc Prof Haber recommended right shoulder surgery. The applicant was experiencing restriction, pain and stiffness and particular difficulty going to sleep at night. The applicant was unable to exercise or swim because of severe shoulder pain and stiffness. The applicant was restricted with domestic duties. Assoc Prof Haber sent a request for surgery to the insurer, which was declined on 31 July 2018.

20. On 6 August 2019, the applicant consulted Assoc Prof Haber and underwent a further ultrasound in his rooms. Assoc Prof Haber confirmed that the applicant needed the right shoulder surgery as previously recommended.

21. The applicant said he wished to have the surgery as the disability and pain were affecting his daily living too much.

Radiological investigations

22. There are a series of reports of radiological investigations involving the applicant's right shoulder in evidence. An ultrasound performed on 8 July 1999 suggested tendonitis of the right supraspinatus tendon resulting in mild impingement under the acromial process. No tear was otherwise seen in the rotator cuff.

23. An x-ray and ultrasound of the right shoulder on 16 July 2004 showed osteophytic degenerative changes associated with supraspinatus tendinopathy.

24. An MRI performed on 26 November 2012, showed moderate AC joint degenerative arthropathy, moderate patchy supraspinatus tendonosis with possible small internal insertional tears and mild subscapularis tendonosis.

25. An ultrasound of the right shoulder performed on 13 December 2017 showed "moderate size full thickness tear of the distal supraspinatus tendon."

26. The report of an MRI performed on 9 June 2018 indicated:

> "1. Partial thickness bursal sided tear involving the anterior and to a minimal extent the mid third of the supraspinatus. Mild bursal sided fraying of musculotendinous junction of the supraspinatus.
>
> 2. Small partial-thickness articular sided tear of the superior and lateral subscapularis."

27. An amended MRI report dated 5 December 2018 noted:

> "Dr Haber informed me he had scanned the patient on ultrasound in his rooms, which has a higher resolution than MRI, suggested a higher-grade tear than that seen on MRI. On further discussion with Dr Mark Haber and on reviewing the images together with Dr Mark Haber, the consensus was that tear was still mainly bursal sided (measurements given in original report) with a small partial thickness articular sided component that involves approximately two thirds of tendon thickness, with the rest still intact at the time of the scan."

Associate Professor Haber

28. Assoc Prof Haber has provided a series of reports dated between 8 May 2018 and 29 October 2019.

29. In a report dated 8 May 2018, Assoc Prof Haber indicated that ultrasound screening of the rotator cuff tendons and subacromial bursa were performed:

> "A small full thickness rotator cuff tear involving supraspinatus tendon was identified measuring 11 mm longitudinal by 8 mm transverse."

30. In a report to the insurer on the same date, Assoc Prof Haber said the applicant had been referred for assessment of bilateral shoulder pain. The applicant had described developing pain following carrying out storm damage repair for the New South Wales Fire Brigade on 18 April 1999. The applicant had two previous surgeries on the right shoulder.

31. Ultrasounds performed in the clinic on that day confirmed the presence of rotator cuff tears, the right larger than the left. Examination demonstrated tenderness localised to the subacromial region. There was significant restriction and forward elevation and internal rotation and diminished power on external rotation.

32. Assoc Prof Haber recommended an impingement test performed by injecting the subacromial bursa with a local anaesthetic and steroids. If this provided significant symptomatic relief this would be highly suggestive of a subacromial impingement syndrome. In a report dated 7 June 2018, Assoc Prof Haber reported that the impingement test provided a short-term benefit only. Assoc Prof Haber requested an MRI of the right shoulder.

33. On 21 June 2018, Assoc Prof Haber indicated that he had reviewed the MRI of the applicant's right shoulder and discussed the condition and treatment options with the applicant including rotator cuff repair surgery, physiotherapy, cortisone injections and a wait-and-see approach. Due to the presence of a full thickness tear and persistent symptoms, Assoc Prof Haber recommended right shoulder rotator cuff repair. Assoc Prof Haber gave the opinion:

> "From the history obtained I do believe the patient's employment is a substantial contributing factor to the current condition and need for surgery. It is hoped surgery will alleviate the patient's symptoms and assist in them returning to pre-injury duties. I believe this procedure is reasonable and necessary and is the most appropriate treatment as rotator cuff tears have no ability to heal without surgical repair."

34. In a report dated 21 August 2018, Assoc Prof Haber indicated that he had been made aware of the recommendations of the respondent's medicolegal expert, Dr Ho. Assoc Prof Haber responded as follows:

> "On review today Alan did demonstrate painful range of motion but this is not inconsistent with the diagnosis of rotator cuff tear. I also note the MRI report was done by a locum for the practice and I feel understated the significance of the rotator cuff tear. As per the previous reports, my recommendation is still for rotator cuff repair surgery as I do believe he does have on a full thickness or near full thickness rotator cuff tear. I have also suggested a review of the initial MRI by Wollongong Diagnostics.
>
> I would also suggest an independent review as I understand Alan did not have a positive connection with Dr Ho which may have also created a misunderstanding. It was my impression that Alan seemed quite positive about ongoing management and did not demonstrate features of being depressed or having a complex regional pain syndrome."

35. Assoc Prof Haber reviewed the applicant on 6 August 2019 and, on 24 September 2019, reported:

> "Previous MRI of the right shoulder from 12.2018 reported a partial thickness tear of the supraspinatus. On my review of the MRI, it is a full or near full thickness supraspinatus tear with 1.2 cm of tendon retraction.
>
> A check ultrasound of both shoulders was performed at this consultation on 6 August 2019. This has confirmed further retraction of both tears with the right shoulder now demonstrating a full thickness tear with 12 mm of tendon retraction and the left shoulder with 7 mm of tendon retraction.
>
> He continues to be symptomatic and the tears are increasing in size. As mentioned in previous reports, I have recommended arthroscopic rotator cuff repair surgery to the right shoulder.
>
> From the history obtained I do believe the patient's employment is a substantial contributing factor to the current condition and need for surgery. I believe his current capacity for work is related to the shoulder injury only. It is hoped surgery will alleviate the patient's symptoms and assist in them returning to pre-injury duties. I believe this procedure is reasonable and necessary and is the most appropriate treatment for rotator cuff tears as rotator cuff tears have no ability to heal without surgical repair.

I am not aware of any barriers and/or non-compensated issues preventing Alan from achieving a full recovery to reinjury duties. I do not have the concerns regarding the validity of this claim."

36. Assoc Prof Haber considered surveillance evidence and further reports from Dr Ho in his final report of 29 October 2019 and stated:

> "According to the attached reports from Prof Murrell dated 2000 and 2004, Alan developed early (age 44) right shoulder rotator cuff tendonitis and possible rotator cuff tear. Cuff failure at this early age is uncommon without any significant contributing factor.
>
> He underwent a subacromial decompression in 2000 and later in 2004 on a distal clavicle resection.
>
> From these letters it seems that he had recovered well from the earlier operations. Back in the early 2000's these procedures were the common practice for the above-mentioned condition.
>
> Nowadays, we know that previous subacromial decompression procedures did not address the underlying cuff pathology. Many of the patients did have short-term benefit, but unfortunately later on continued to suffer from ongoing pain and cuff failure.
>
> As for the above, I do believe Alan's current condition and the need for surgery is related to his work-related injury. I have not changed my diagnosis or recommendation."

Dr Endrey-Walder

37. The applicant has filed a medicolegal report prepared by general and trauma surgeon Dr P Endrey-Walder dated 4 December 2018. The report does not appear to have been prepared for the purposes of the present proceedings and deals with injury to a number of body parts aside from the applicant's right shoulder.

38. Dr Endrey-Walder's examination revealed moderate restriction in the range of movement of the applicant's right shoulder. Dr Endrey-Walder gave the opinion:

> "Dr Haber recommended surgery for his right shoulder condition, and given the multiple pathologies identified on the MRI scan, I believe that this is a perfectly reasonable recommendation."

Dr Ho

39. The respondent relies on medicolegal reports prepared by orthopaedic surgeon, Dr Yiu Key Ho, dated 10 May 2018, 28 June 2018, 5 July 2018 and 30 August 2019.

40. In the first report, Dr Ho took a history of the injury that was consistent with the other evidence. Dr Ho noted that the applicant was taking Celebrex, Panadol Osteo and Lyrica as well as medication for psychiatric problems.

41. Dr Ho noted that the applicant was medically discharged in 2006 and had not worked subsequently.

42. On examination, Dr Ho noted that the applicant's shoulders were both very stiff and there was obvious muscle wasting. Doctor Ho said he did not understand why active movement was so poor because passively there was very good external rotation and internal rotation in neutral positions. The applicant's rotator cuff was weak.

43. Dr Ho indicated that the applicant had brought radiological reports of an ultrasound of his right shoulder dated 13 December 2017 indicating a full thickness tear of the supraspinatus.

44. Dr Ho gave the opinion:

> "Both shoulders have inferior function but I find it difficult to explain this just by the so-called tendon tear on the ultrasound because the function is so poor, his response to the injection was not as expected and I am worried that there are a lot of psychosomatic issues in this particular case because Mr Paine claims to be deeply depressed and excessively anxious with chronic stress and chronic pain. He even mentioned to me that he is seeking legal advice and suing for medical negligence.
>
> In relation to his shoulders, I would like to see the correspondence from Dr Haber and probably when Mr Paine did not have significant pathology on investigation and then the shoulder being so stiff, I wonder what will be the expected surgical result and if Mr Paine is a good surgical candidate. He told me that Dr Haber planned to do the operation on the right side and review his response on the left side to steroid."

45. Dr Ho subsequently reviewed correspondence from Dr Haber dated 21 June 2018 in which Dr Haber referred to an MRI scan of the right shoulder showing partial-thickness bursal-sided tear of the anterior extending to the middle third of the supraspinatus and a small partial-thickness articular side tear of the superolateral subscapularis. Dr Ho noted that Dr Haber referred to the presence of a full thickness tear in recommending an operation but this seemed to be contradictory to the MRI scan report.

46. Doctor Ho reiterated his view that the applicant's shoulder was exceptionally stiff and that this could not be explained even if there was a full thickness tear of the rotator cuff. Dr Ho said it would be interesting to look at the actual radiological report. Dr Ho said,

> "Usually we try not to operate on a partial thickness tear because we may not be able to improve the outcome really very well and even a full thickness tear does not lead to an operation straightaway."

47. The report of an MRI scan performed on 8 June 2018 was considered by Dr Ho in his report of 5 July 2018, based on which Dr Ho concluded:

> "I find it difficult in this case to justify any operative treatment. As mentioned in my previous report, Mr Paine's pain behaviour and presentation is not as would be expected with relatively minor pathology on the MRI scan. The choice of treatment is very difficult but I believe in this particular case that even performing an operation does not mean we are going to see a good result. In my opinion, based on the MRI scan findings, there is not enough pathological evidence to undertake shoulder surgery."

48. Dr Ho was provided with additional material prior to his most recent supplementary report of 30 August 2019 including medical and surveillance evidence, MRI scan reports and ultrasound reports. Dr Ho said that the most recent MRI scan on 5 December 2018 mentioned a partial-thickness tear rather than a full thickness tear. Irrespective, Dr Ho said it would be difficult to associate this problem with the work injury dating back to 1999. This was said to be a problem associated with normal wear and tear in every patient. As the applicant retired in 2006 and an MRI scan in 2012 showed only tendonosis without any tear, Dr Ho said all the pathology probably happened after the applicant retired.

49. Dr Ho said that assuming the applicant did have a full thickness tear, given his poor response to previous surgeries and pain-oriented behaviour, he would not be a candidate for further surgery. Dr Ho said he would not recommend surgery even if there was a full thickness tear. Dr Ho concluded that the operation was not reasonably necessary as a result of the work injury.

Respondent's submissions

50. Counsel for the respondent, Mr Parker noted that while injury was not disputed, liability for the surgery had been disputed in two notices issued pursuant to s 78 of the 1998 Act. Mr Parker said there was essentially a medical dispute between Assoc Prof Haber and Dr Ho, noting that Dr Endrey-Walder did not provide a detailed opinion on the need for surgery in his report.

51. Mr Parker noted that Dr Ho had prepared several reports. Dr Ho had given an opinion that the proposed surgery was not reasonably necessary as a result of the injury based on the radiology, the potential effectiveness of the surgery and his view as to the cause of the pathology.

52. Mr Parker noted that Dr Ho considered the radiology showed only a partial tear rather than a full thickness tear. Dr Ho gave the view that the surgery would not be effective in treating only a partial tear. Dr Ho also noted that non-organic, psychological issues may also prevent the surgery from being effective. Dr Ho further considered that the applicant's current presentation was a reflection of the normal progression of the applicant's degenerative pathology, since the applicant was medically retired.

53. Mr Parker submitted that I would prefer the opinions of Dr Ho over the opinions of Assoc Prof Haber. Mr Parker said that Assoc Prof Haber's opinions were characterised by broadbrushed generalisations. Assoc Prof Haber's reports lacked reasoning and appeared to be produced from a precedent document. For example, the report of 21 June 2018 made reference to the applicant's ability to return to pre-injury duties, something which was irrelevant to the applicant's circumstances. Mr Parker submitted that Assoc Prof Haber had given conclusions without providing persuasive explanations, in comparison to the reports of Dr Ho.

54. Mr Parker said that Assoc Prof Haber had failed to address Dr Ho's view that surgery was inappropriate for a partial thickness tear. Mr Parker also said that Assoc Prof Haber appeared to take the view that the applicant had no psychological difficulties which was contrary to the notes of Dr Azam.

55. Mr Parker said it was relevant that the applicant had two unsuccessful previous surgeries to his right shoulder.

56. Mr Parker referred me to the radiological investigations and submitted that they did not demonstrate a full thickness tear. The radiological investigations prior to the applicant's retirement showed different pathology to the more recent investigations. Mr Parker said this supported Dr Ho's view that the present pathology was constitutional

Applicant's submissions

57. Counsel for the applicant, Mr Stockley, noted that the applicant relied on the opinion of an Associate Professor in orthopaedic surgery, who was treating the applicant's right shoulder symptoms and who had recommended the surgery claimed. Mr Stockley said it would take a persuasive contrary opinion for an arbitrator to find that the surgery was not reasonably necessary in light of Assoc Prof Haber's opinion.

58. With regard to the question of causation, Mr Stockley submitted that the correct test was whether the accepted injury made a material contribution to the proposed treatment, referring me to the decision in *Murphy v Allity Management Services Pty Ltd*[1]. Mr Stockley conceded that the applicant's shoulder condition appeared to have deteriorated since the cessation of his employment but said the relevant question was whether the injury had "materially contributed" to the need for surgery.

[1] [2015] NSWWCCPD 49.

59. Mr Stockley referred me to the history of injury set out in a report of Dr James Bodel dated 24 April 2007 and the investigations available to him at the time. Mr Stockley submitted that Dr Bodel had expressed the view that the applicant had significant rotator cuff pathology in his right shoulder. Mr Stockley said an inference was clearly available that Dr Bodel related pathology to the injury in 1999. Mr Stockley submitted that evidence would satisfy any concern I might have with regard to causation.

60. Mr Stockley observed that Dr Ho appeared to have been provided with copies of radiological reports but there was no evidence of him having viewed films himself. In contrast, Assoc Prof Haber indicated that he had looked at the films himself and concluded that there was a full thickness tear to the applicant's shoulder.

61. Mr Stockley submitted that I would find for the applicant on the question of causation and dismiss the opinion of Dr Ho on the question of whether there was a full thickness tear based on his failure to view the radiological investigations.

62. On the question of whether surgery would be effective given the applicant's psychological symptoms, Mr Stockley noted that Assoc Prof Haber did not share Dr Ho's view. Mr Stockley noted that the applicant had undergone a total knee replacement surgery in 2019 which had been very helpful and improved the applicant's pain and function. To the extent that the applicant had some degree of psychological frailty, it would not be of such a nature as to reduce the effectiveness of surgery.

63. Mr Stockley concluded there was no basis for not accepting the opinion of Assoc Prof Haber.

Respondent's submissions in reply

64. Mr Parker submitted that there remained some uncertainty with regard to what the radiology showed. The updated recent MRI report still showed only a partial thickness tear. Mr Parker said I could not find that Dr Ho had not reviewed the scans simply because he did not specifically refer to having done so in his report.

65. Mr Parker conceded that Assoc Prof Haber appeared to have performed his own ultrasound which confirmed full thickness tear but noted that he referred to a recent MRI which was not in evidence. There remained uncertainty as to the pathology in the applicant's right shoulder. Mr Parker submitted that it might be appropriate for the matter to be referred to an AMS for an independent, non-binding opinion.

FINDINGS AND REASONS

66. Section 9 of the *Workers Compensation Act 1987* (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.

67. 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)."

68. In considering whether the surgery proposed by Assoc Prof Haber "results from" the injury on 18 April 1999, the authorities require me to conduct a commonsense evaluation of the causal chain. In *Kooragang Cement Pty Ltd v Bates*[2], Kirby P said:

> "… it has been well recognised in this jurisdiction that an injury can set in train a series of events. If the chain is unbroken and provides the relevant causative explanation of the incapacity or death from which the claim comes, it will be open to the Compensation Court to award compensation under the Act.
> …
> The result of the cases is that each case where causation is in issue in a workers compensation claim, must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from', is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent death or injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a commonsense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation."[3]

69. The need for surgery can arise from multiple causes for the purposes of s 60 of the 1987 Act. In *Murphy v Allity Management Services Pty Ltd* Roche DP stated[4]:

> "…That is because a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973) 47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cliff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act.
>
> Ms Murphy only has to establish, applying the commonsense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary 'as a result of' the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40]–[55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."

70. There is also dispute in this case as to whether the surgery is "reasonably necessary". In *Diab v NRMA Ltd*[5] Roche DP, referring to the decision in *Rose v Health Commission (NSW)*[6], 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.

[2] (1994) 35 NSWLR 452; 10 NSWCCR 796.
[3] At 462-463.
[4] At [57].
[5] [2014] NSWWCCPD 72.
[6] [1986] NSWCC 2; (1986) 2 NSWCCR 32.

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.'"

71. 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*[7]:

> "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."

72. 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."

73. It is not in dispute that the applicant sustained an injury to his right shoulder on 18 April 1999. Mr Stockley referred me to the description of the applicant's injury in the report of Dr Bodel dated 24 April 2007. That report was prepared for the insurer and formed part of the basis for a complying agreement between the parties under s 66A of the 1987 Act in 2007. Dr Bodel made a diagnosis of injury in the nature of "significant rotator cuff pathology". The reports of the applicant's first treating surgeon, Prof Murrell, in 1999 and 2000, describe a persistent supraspinatus tendonitis.

74. The evidence before me suggests that since the time of the applicant's injury in April 1999 he has experienced pain and restrictions in his right shoulder. There have been two attempts to address those symptoms surgically by Prof Murrell. Whilst the applicant was able to return to duties, he says he never fully recovered. The applicant continued to receive treatment periodically and he describes his symptoms as gradually worsening.

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[7] [1997] NSWCC 1; 14 NSWCCR 233.

75. The respondent has denied liability for the surgery in part relying on Dr Ho's opinion that the pathology now shown on the radiology is different to that which was present prior to the cessation of duties for the respondent. Dr Ho described the current pathology as representing the normal progression of degenerative pathology and unrelated to the applicant's work.

76. The radiological reports before me confirm that the pathology shown in the right shoulder has changed over time. An ultrasound performed on 8 July 1999 suggested tendonitis of the supraspinatus tendon resulting in mild impingement but with no tear seen. Investigations in 2004 showed supraspinatus tendonitis. By 2012 there was moderate patchy supraspinatus tendonosis with possible small internal insertional tears. Ultrasounds performed in in December 2017 and May 2018 showed a moderate size full thickness tear of the supraspinatus tendon. Although an MRI performed in 2018 showed a partial thickness tear to the supraspinatus and mild bursal fraying of the musculotendinous junction of the supraspinatus, a further ultrasound performed by Assoc Prof Haber in August 2019 again showed a full thickness tear, now with further retraction.

77. It is not necessary, as might be suggested by Dr Ho's opinion, that the events on 18 April 1999 caused the pathology now shown in the radiological investigations. If, however, the injury which occurred on 18 April 1999, has materially contributed to the present need for treatment, albeit with the passage of time and the progression of degenerative changes, the treatment will be compensable.

78. Associate Prof Haber has given an opinion that based on the history obtained, employment was a substantial contributing factor to the current condition and need for surgery. In his most recent report, Assoc Prof Haber indicated that he had reviewed reports from Prof Murrell dated in 2000 and 2004 which showed the applicant developed right shoulder cuff tendonitis and possible rotator cuff tear at an early age which he regarded as "uncommon" without any significant contributing factor.

79. It is fair to say that Assoc Prof Haber does not specifically engage with Dr Ho's view as to the different pathology now shown. Mr Parker criticised the lack of detailed explanation in Assoc Prof Haber's reports. It is important to note, however, that Assoc Prof Haber has prepared his reports as a treating surgeon and not as a medicolegal examiner like Dr Ho. The only medicolegal opinion for the applicant is contained in the report of Dr Endrey-Walder. Unfortunately, that report appears to have been prepared for a different purpose and sheds little further light on this issue.

80. Having regard to the applicant's evidence that there was never complete resolution of his shoulder symptoms following the injury, the opinion of Assoc Prof Haber, and the radiological evidence confirming continued and deteriorating pathology at the supraspinatus tendon, I am satisfied that there continued to be a causal connection between the injury and the present pathology for which surgery has been recommended.

81. There is, however, a dispute as to what that pathology is. Dr Ho has noted that the MRI performed on 9 June 2018 showed only a partial thickness tear to the supraspinatus. In his second report, Dr Ho commented on the apparent inconsistency between the MRI scan and the view expressed by Assoc Prof Haber that there was a full thickness tear. This is despite Dr Ho having been given the radiological reports of an ultrasound performed in December 2017 which indicated a full thickness tear. A full thickness tear was shown on the ultrasound performed by Dr Haber on 8 May 2018. A further ultrasound performed in Assoc Prof Haber's rooms in August 2019 also indicated a full thickness tear with further retraction.

82. The amended MRI report and Dr Haber's reports of 21 August 2018 and 24 September 2019 confirm his view that the MRI understated the extent or significance of the rotator cuff tear. The amended MRI report noted that the ultrasound in Assoc Prof Haber's rooms had a higher resolution than MRI. Associate Prof Haber has indicated that his review of the MRI showed a full or at least near full thickness supraspinatus tear.

83. Dr Ho does not indicate whether he was able to view the imaging himself. His most recent report indicates only that he had been provided with the MRI and ultrasound reports. In providing an opinion, Dr Ho appears to rely primarily on the relatively minor pathology shown on the MRI without engaging with the more significant pathology shown on the ultrasounds.

84. Weighing the evidence, I am satisfied that Assoc Prof Haber has expressed a reliable view as to the nature of the pathology in the applicant's shoulder. Assoc Prof Haber has engaged in a thorough review of the MRI imaging and performed two ultrasounds in his rooms, which together with a third, independently performed, ultrasound showed a full thickness tear.

85. The third basis on which the respondent disputes liability for the surgery is Dr Ho's view as to the potential effectiveness of the surgery. Dr Ho has said he would not recommend the surgery even if there was a full thickness tear due to the applicant's previous response to surgeries and pain-oriented behaviour. Dr Ho had difficulty reconciling the applicant's presentation on examination with the pathology shown noting that the applicant appeared depressed and excessively anxious.

86. The medical evidence before me confirms that the applicant has experienced psychological symptoms related to his ongoing chronic pain. The applicant has received treatment for those symptoms but apart from the report of Dr Ho there is nothing from the applicant's treating practitioners to suggest that those symptoms indicate that the surgery is either not reasonably necessary or that the results would be sub-optimal. There is evidence in Dr Ho's reports that his interactions with the applicant had been difficult.

87. Assoc Prof Haber formed a different impression of the applicant's presentation. Assoc Prof Haber has said that he had no concerns regarding the validity of the applicant's claim and was not aware of any barriers preventing the applicant from achieving a full recovery. Assoc Prof Haber said the applicant seemed quite positive about ongoing management and did not demonstrate to him any features of being depressed or having a complex regional pain syndrome.

88. Mr Stockley has noted also that the applicant has recently undergone surgery in respect of a knee injury with good results. Although the two previous surgeries to the applicant's shoulder have been described in parts of the evidence as unsuccessful, I am not satisfied that this necessarily leads to the inevitable conclusion that the surgery now proposed by Assoc Prof Haber would be similarly unsuccessful. In his final report, Assoc Prof Haber has explained that the procedures performed by Prof Murrell were common practice for the applicant's condition in the 2000s. It is now known that those procedures did not address the underlying cuff pathology and that patients often had short-term benefit but continued to suffer ongoing pain and cuff failure.

89. Assoc Prof Haber has given the view that the surgery he proposes to perform should alleviate the applicant's symptoms and is the most appropriate treatment for rotator cuff tears as tears have no ability to heal without surgical repair. I note that Dr Endrey-Walder has given an opinion that the surgery proposed by Assoc Prof Haber is a "perfectly reasonable recommendation".

90. The applicant attempted a range of alternative treatments prior to requesting the surgery including, multiple causes of physiotherapy, hydrotherapy, medication and injections over a period of many years. The applicant says he is experiencing restriction, pain and stiffness which is interrupting his sleep at night and unacceptably affecting his quality of life.

91. Assoc Prof Haber has estimated the cost of the surgery at $9,000 which is not an insignificant sum. Weighing the totality of the evidence, however, I am satisfied that the surgery proposed is appropriate and potentially effective.

92. I am satisfied that the right rotator cuff repair surgery proposed by Assoc Prof Haber is reasonably necessary as a result of the injury on 18 April 1999. There will be an order for the respondent to pay the costs of and incidental to the surgery pursuant to s 60 of the 1987 Act.

Costs

93. As the applicant was a firefighter, this application is exempt from the repeal of the costs provisions.

94. The applicant has made submissions that any costs ordered should be subject to an uplift with respect to complexity in the range of 15 to 20%. The respondent makes no submissions other than to say that any uplift should apply to both parties if it applies at all.

95. I am not satisfied the present matter involved any particular complexity. The dispute involved a single issue and was capable of being dealt with by counsel in relatively brief submissions at arbitration hearing.

96. I accept that the injury does have a long history and a moderately large volume of medical evidence was filed in these proceedings. Not all of that evidence was ultimately relevant to the issue presently in dispute. In essence, the matter involved a difference of medical opinion between Assoc Prof Haber and Dr Ho.

97. I am not persuaded that an uplift is appropriate in the circumstances. As the applicant has been successful, I will order the respondent to pay the applicant's costs as agreed or assessed.

SUMMARY

98. The right rotator cuff repair surgery proposed by Assoc Prof Haber is reasonably necessary as a result of the injury on 18 April 1999.

99. The respondent to pay the costs of and incidental to the surgery pursuant to s 60 of the 1987 Act.

100. The respondent to pay the applicant's costs as agreed or assessed.