WORKERS COMPENSATION COMMISSION

STATEMENT OF REASONS FOR DECISION OF THE APPEAL PANEL IN RELATION TO A MEDICAL DISPUTE

Matter Number:	**M1-2037/20**
Appellant:	**Jocelyn Lesley Perry**
Respondent:	**State of New South Wales (Central Coast Local Health District)**
Date of Decision:	**2 February 2021**
Citation No:	**[2021] NSWWCCMA 19**

Appeal Panel:	
Arbitrator:	**Ross Bell**
Approved Medical Specialist:	**Dr Neil Berry**
Approved Medical Specialist:	**Dr John Garvey**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 29 September 2020, Jocelyn Lesley Perry, the appellant, lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Richard Crane, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 14 September 2020.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - the assessment was made on the basis of incorrect criteria,
    - the MAC contains a demonstrable error.

3. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground(s) of appeal on which the appeal is made.

4. The Workers compensation medical dispute assessment guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the Workers compensation medical dispute assessment guidelines.

5. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* ed 1 April 2016 (SIRA Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

RELEVANT FACTUAL BACKGROUND

6. It is convenient to extract the history reported by the AMS at Part 4 of the MAC,

> "Brief history of the incident/onset of symptoms and of subsequent related events, including treatment:
>
> On 11 June 2009, the applicant was transferring a patient who was cognitively impaired. She had the impression she was about to be assaulted and moved sharply backwards, feeling a "pop" in the low back. This was quite painful but she did not feel it warranted being reported and generally she did not "think much about it".
>
> She was then seen at Long Jetty Medical Centre by a doctor whose name she can't recall. She recalls complaining of pain in the low back, moving to the right lower extremity, and passing between the posterior aspect of the thigh to the heel. She felt this pain was described as 6/10 for intensity. She was advised to take Panadol or Panadol Forte, which she did for about four days but became constipated and changed the Panadol Forte to Panadol Osteo.
>
> Ms Perry missed about three or four days at work and then resumed her normal full-time duties as an Enrolled Nurse. She believes she saw her usual general practitioner a week or so later. She is uncertain as to whether she was advised to receive physiotherapy assistance and there was no specialist referral.
>
> Low back pains continued until Ms Perry decided she would be unable to continue her work and she stopped work on 9 November 2011. There has been no work since that time, as Ms Perry notes increasing low back pain with prolonged sitting or standing.
>
> After ceasing her work, she used her leave entitlements and then QBE payments commenced in June 2012 and eventually ceased in 2018. Since that time, Ms Perry has received a carer's payment for looking after her husband. The pain in the low back continued with variation as concerns intensity.
>
> In 2011, Ms Perry was prescribed Celebrex for her pains but after two or three months, she discontinued this as she felt it was causing her uncomfortable gastroesophageal reflux symptoms."

PRELIMINARY REVIEW

7. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the WorkCover Medical Assessment Guidelines.

8. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination for the reasons given below.

EVIDENCE

Documentary evidence

9. The Appeal Panel has before it all the documents that were sent to the AMS for the original medical assessment and has taken them into account in making this determination.

Medical Assessment Certificate

10. The parts of the medical certificate given by the AMS are set out, where relevant, in the body of this decision.

SUBMISSIONS

11. Both parties made written submissions. They are not repeated in full but have been considered by the Appeal Panel. In summary the parties submit,

Appellant

12. The AMS has erred in requiring "organic" signs in the digestive tracts, which is a more difficult test to meet for Ms Perry, when there is no such requirement in AMA5 paragraph 6.1a or the SIRA Guidelines at paragraph 16.9.

13. The AMS records that Ms Perry experiences retrosternal discomfort with a feeling of regurgitation which should have been found to comprise signs and symptoms in terms of paragraph 6.1a of AMA5.

14. Paragraph 16.9 of the SIRA Guidelines does not require objective evidence for the upper digestive tract, but only clinical signs or objective evidence.

15. The fact that Ms Perry was to undergo a gastroscopy in the future indicates that there are objective signs of upper tract disease.

16. The AMS has erred in not accepting the assessment of Associate Professor Bolin who assessed 6% WPI for the upper tract. Both Associate Professor Bolin and Dr Ruppin found symptoms and signs supporting an impairment finding.

Respondent

17. The AMS based the assessment on correct criteria. Paragraph 16.9 of the SIRA Guidelines provides that in the absence of clinical signs or other objective evidence of upper digestive tract disease, anatomic loss or alteration 0% WPI is to be assessed.

18. The AMS found minor symptoms of upper gastrointestinal discomfort due to the medication but this was when Ms Perry was taking Celebrex in 2011 but she discontinued this after two or three months. The retrosternal discomfort with a feeling of regurgitation referred to by the AMS dates to the Celebrex in 2011. The current medications do cause reflux symptoms which is responding well to Nexium. The symptoms from 2011 associated with Celebrex are no longer relevant.

19. There was no guarding or masses in the abdomen. There was a slight degree of tenderness in the left subcostal area, but bowel sounds were normal.

20. The AMS was not obliged to adopt the assessment of either Dr Bolin (6%) or Dr Ruppin (1%) but was required to conduct his own assessment. The AMS found no objective evidence of impairment and there can be no demonstrable error.

21. The MAC should be confirmed.

FINDINGS AND REASONS

22. The procedures on appeal are contained in s 328 of the 1998 Act. The appeal is to be by way of review of the original medical assessment, but the review is limited to the grounds of appeal on which the appeal is made.

23. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 the Court of Appeal held that the Appeal Panel is obliged to give reasons. Where there are disputes of fact it may be necessary to refer to evidence or other material on which findings are based, but the extent to which this is necessary will vary from case to case. Where more than one conclusion is open, it will be necessary to explain why one conclusion is preferred. On the other hand, the reasons need not be extensive or provide a detailed explanation of the criteria applied by the medical professionals in reaching a professional judgement.

Ground of appeal – alleged failure of AMS to find symptoms and signs in terms of paragraph 6.1a. and Tables 6-3 or 6-4 of AMA5, and paragraph 16.9 of the SIRA Guidelines

24. Paragraph 16.9 of the SIRA Guidelines provides,

> "Effects of analgesics on the digestive tract:
>
> - AMA5 Table 6-3 (p 121) Class 1 is to be amended to read 'there are symptoms and signs of digestive tract disease'.
>
> - Nonsteroidal anti-inflammatory agents, including Aspirin, taken for prolonged periods can cause symptoms in the upper digestive tract. In the absence of clinical signs or other objective evidence of upper digestive tract disease, anatomic loss or alteration a 0% WPI is to be assessed."

25. In the history extracted above the AMS noted, "In 2011, Ms Perry was prescribed Celebrex for her pains but after two or three months, she discontinued this as she felt it was causing her uncomfortable gastroesophageal reflux symptoms".

26. Under "Present symptoms" the AMS recorded,

> "Ms Perry also describes upper abdominal and retrosternal discomfort with a feeling of regurgitation but this was only notable while she was taking Celebrex. The reflux symptoms she has at present respond well to taking Nexium and she has to watch her diet so she has restricted intake of fatty foods and also acidic foods and wine. Ms Perry also describes occasional bouts of diarrhoea which may occur every few days and she believes these are probably related to dietary intake. The bowel motion is usually normally formed and she feels the bowel looseness may be associated when the back discomfort is more significant. She does not take any medications for her bowels.
>
> Ms Perry stated she was due to have a gastroscopy in three months' time."

27. At Part 10.b. the AMS explains,

> "There are minimal symptoms of upper gastrointestinal tract and also the lower gastrointestinal tract, but there are no signs of organic disease. Under the AMA5 Guides, symptoms and signs are required to find impairment of the gastrointestinal tract and as there are no signs, both areas are found to be 0% WPI."

28. It is clear what the AMS means by "organic" disease. Use of this term did not "raise the bar" for Ms Perry as submitted for her but merely states the obvious. Non-organic findings are functional and are not objective clinical signs for the purpose of establishing rateable digestive tract disease.

29. It is also apparent on the face of the Certificate that the AMS took the history of "upper abdominal and retrosternal discomfort with a feeling of regurgitation but this was only notable when she was taking Celebrex." The symptoms were "notable" in 2011 in association with Celebrex, but the current mild symptoms are reiterated when the AMS addresses Associate Professor Terry Bolin's assessment. The AMS says,

> "I considered the mild symptoms of reflux are well controlled with Nexium and the possible diagnosis of irritable bowel syndrome, in the absence of objective evidence of colon or rectal disease, does not attract impairment under the NSW Workers Compensation Commission Guidelines."

30. There was a gastroscopy planned at the time of the assessment by the AMS, but this would be unnecessary to make the assessment. There is a history of improvement after stopping Celebrex in 2011 and of Nexium being effective. This is consistent with the clinical findings of the AMS. Contrary to the submission of the appellant the referral for a gastroscopy does not establish that there were "objective signs of upper tract disease and/or impairment." These elements are established by the examination of the AMS together with the application of the relevant criteria.

31. The Panel notes the importance of the exercise of clinical judgement by the AMS in the process of assessment. As the Supreme Court noted in *Glenn William Parker v Select Civil Pty Limited* [2018] NSWSC 140 (*Parker*),

> "In *Ferguson v State of New South Wales* [2017] NSWSC 887 at [23], Campbell J cited with approval *NSW Police Force v Daniel Wark* [2012] NSWWCCMA 36 ('*Wark*'), where it is stated at [33]:
>
> > '…the pre-eminence of the clinical observations cannot be understated. The judgment as to the significance or otherwise of the matters raised in the consultation is very much a matter for assessment by the clinician with the responsibility of conducting his/her enquiries with the applicant face to face. …'"

32. The appellant submits that the AMS has not taken account of the assessment of Associate Professor Bolin and should also have assessed Ms Perry at 6% WPI. However, the Panel notes that it is not required of the AMS to adopt any of the medical opinions relied upon by the parties. The AMS is required to exercise their own clinical judgement, and a difference of opinion is not a ground of appeal. In *Mahenthirarasa v State Rail Authority of New South Wales & Ors* [2007] NSWSC 22 Malpass AJ considered the Second Reading speech referring to s 327 of the 1998 Act, and made the comment that, "A demonstrable error would essentially be an error for which there is no information or material to support the finding made – rather than a difference of opinion."[1] The clinical findings of the AMS are key elements of the information upon which the findings were made.

33. The appellant also submits that both Associate Professor Bolin and Dr Ruppin found symptoms and signs for the upper tract for which impairment should be assessed. The Panel notes that Dr Ruppin in fact found intermittent upper tract symptoms which is insufficient to satisfy the AMA5 criteria.

34. The appellant concentrates on the upper tract in the submissions, but there is no error apparent in relation to either the upper or the lower digestive tract.

Findings

35. The grounds of appeal are not made out. The assessment was not based on incorrect criteria. The Panel discerns no demonstrable error on the face of the Certificate.

36. For these reasons, the Appeal Panel has determined that the MAC issued on 14 September 2020 is confirmed.

[1] Also see *Ferguson v State of New South Wales* [2017] NSWSC 887 [24].

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

A Jackson

Ann Jackson
Dispute Services Officer
As delegate of the Registrar