WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **6164/19**
Applicant: **Janice-Marie Longworth**
Respondent: **Secretary, Department of Transport**
Date of Determination: **26 February 2020**
Citation: **[2020] NSWWCC 52**

The Commission determines:

1. The respondent is to pay the applicant's s 60 expenses of and incidental to the surgery proposed by Dr M Coughlan being anterior lumbar interbody fusion at L4/5 and L3/4.

2. I find that the prescription of medicinal cannabis by Dr Ferris is medical and related treatment within s 59 of the *Workers Compensation Act 1987*.

3. The respondent is to pay the applicant's s 60 expenses of and incidental to the prescription of medicinal cannabis.

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

Catherine McDonald
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 CATHERINE McDONALD, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

G Bhasin

Gurmeet Bhasin
Acting/Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Janice-Marie Longworth was employed by the Secretary, Department of Transport (the Department) as a driving examiner. On 28 March 2018, she was injured whilst performing a driving test when a learner driver forcefully applied the brake, causing her to be thrown forward and backwards into the seat, suffering pain in her lower back.

2. Ms Longworth claimed compensation and her claim for weekly compensation remains accepted.

3. The issue for determination in these proceedings is whether the Secretary should be ordered to pay for two aspects of her treatment:

   (a) Surgery in the form of an anterior lumbar interbody fusion at L3/4 and L4/5, and
   (b) The provision of Cannabidiol (medicinal cannabis).

4. The Department disputes that the proposed surgery is reasonably necessary medical treatment. It accepts that the provision of Cannabidiol is reasonably necessary but disputes that it is a medical or related expense within the meaning of s 59 of the *Workers Compensation Act 1987* (the 1987 Act).

5. Two different forms of medicinal cannabis have been prescribed for Ms Longworth and I have used that term to refer to both.

PROCEDURE BEFORE THE COMMISSION

6. The matter was listed for conciliation conference and arbitration hearing on 4 February 2020 when Mr Hickey appeared for Ms Longworth and Mr Grant appeared for the Department.

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.

8. Counsel made submissions which were recorded but neither referred to any decisions in which the prescription of medicinal cannabis was considered. At the conclusion of the arbitration hearing, Mr Hickey asked for a period of seven days to provide references to any relevant decisions but none were provided.

EVIDENCE

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

   (a) Application to Resolve a Dispute and supporting documents, and

   (b) Reply.

10. Though Ms Longworth's solicitors had filed two Applications to Admit Late Documents, I was told that it was not necessary to refer to them.

11. There was no oral evidence.

12. Ms Longworth made a statement on 21 November 2019 in which she described the injury and the treatment she has undergone. She said that she returned to work, undertaking non-driving tasks. She ceased work on 28 May 2018. Her general practitioner, Dr Broeders prescribed Diazepam for spasms which helped a little but caused her to suffer side effects.

13. A new general practitioner, Dr Wirthamulla, referred her to Dr Cherukuri, Neurosurgeon, who recommended investigations and a periradicular injection into L5, which Ms Longworth underwent on 4 July 2018. It did not provide relief and she was referred to Dr P Ferris, pain management specialist.

14. Dr Ferris recommended steroid injections for discogenic pain. The first in early March 2019 did not provide relief and Ms Longworth began to develop pain in her coccyx, buttocks and thighs. Dr Ferris recommended another injection at a higher level, which Ms Longworth had on 2 April 2019. Following the injection her pain increased and she was admitted to Shoalhaven Hospital with "discitis and septicaemia."

15. On 30 May 2019, Ms Longworth saw Dr Cherukuri again, who recommended spinal fusion. She decoded to seek a second opinion.

16. At about the same time, Dr Ferris applied to prescribe Cannabidiol. Approval was given on 27 June 2019 and Ms Longworth found it helpful in managing pain. Though it does not take the pain away, it takes the edge of it, allowing her to sleep. It does not cause her to suffer side effects. When the Department's insurer stopped funding Cannabidiol treatment, Ms Longworth was unable to afford it and reduced her dose to make it last longer. Her pain levels increased and she found it difficult to attend physiotherapy and hydrotherapy.

17. On 29 August 2019, Ms Longworth sought a second opinion about surgery from Dr M Coughlan, neurosurgeon. Dr Coughlan also recommended surgery.

Medical evidence

18. Ms Longworth saw Dr Cherukuri for the first time on 29 June 2018. He noted that the pain from Ms Longworth's back radiated down her right leg to the back of the knee and that her calf was sore. She had altered sensation in her right foot but no pain in her left leg. On examination he observed right L5 dermatomal altered sensation and possible altered sensation in the L4 and S1 dermatomes. Dr Cherukuri saw an MRI scan which showed spondylitic changes particularly at L4/5 with minor listhesis at L3/4 and possible foraminal stenosis at L5. He ordered a bone scan and x-rays of the lumbar spine in flexion and extension.

19. On 16 July 2018, Dr Cherukuri said that nerve condition studies and EMG suggested demyelinative right L4/5 radiculopathy indicating that the pain was arising from the spine. A right L5 periradicular injection was booked for the following day.

20. On 19 July 2018, Dr Cherukuri reviewed the x-rays in flexion and extension which showed mild listhesis at L3/4. He advised conservative measure and physiotherapy and that she should "even try to return to work." He recommended review if her symptoms worsened.

21. Ms Longworth saw Dr Ferris who reported on 27 September 2018, noting that she had chronic mechanical low back pain with radicular right leg pain and facet joint arthropathy. He recommended a graded active exercise program and that she re-engage with social activities. He said he was requesting approval for a multidisciplinary pain program and right L4/5 and L5/S1 facet joint injections.

22. On 10 December 2018, Dr Ferris recorded that Ms Longworth had increased pain after the facet joint injections. Her back pain was worse than the leg pain and she was not taking medication. Because the facet joint injections had been unhelpful, Dr Ferris considered that discogenic pain was a more likely diagnosis and that Ms Longworth might benefit from epidural steroid injection. She continued to participate in the STEPP pain program.

23. On 13 February 2013, Ms Longworth's general practitioner, Dr Withamulla, referred her back to Dr Cherukuri, noting that she had undergone the epidural steroid injection but that none of the injections had given long term analgesia. He arranged a further MRI scan which was undertaken on 1 March 2019.

24. On 4 March 2019, Dr Ferris noted that Ms Longworth had no improvement in her pain which was causing her to become increasingly disabled. He recommended bilateral L3/4 facet joint injections and a caudal epidural steroid injection for the coccydinia pain she was now suffering.

25. Dr Cherukuri reviewed Ms Longworth on 29 March 2019, noting that she experienced recurrent episodes of acute back pain radiating to both legs, predominantly the gluteal region and upper thighs but occasionally to the knees and on one occasion to her left lateral toes. Her neck symptoms had worsened and "sometimes her husband has to help her for feeding." Dr Cherukuri noted that the recent MRI showed significant degenerative changes and facet arthropathy without much nerve impingement and no significant change from the previous scan. He recommended some further investigations and said that surgery may have to be considered because there had been an adequate trial of conservative measures.

26. On 26 April 2019, Ms Longworth was discharged from Shoalhaven Hospital, having been admitted on 13 April for sepsis and acute on chronic lumbar pain. A CT scan suggested possible discitis at the site of a recent steroid injection. An MRI scan was inconclusive for discitis but neurosurgeons from Wollongong Hospital agreed it could not be exclude. Following removal of a catheter, which had been used to administer antibiotics, Ms Longworth developed a deep venous thrombosis (DVT) in her right arm at the catheter site.

27. On 8 May 2019, Dr Ferris noted the treatment for infection. He said "she is requesting and I am requesting approval for medicinal cannabis."

28. On 9 May 2019, a delegate of the Secretary of the Commonwealth Department of Health wrote to Dr Ferris approving the import and supply of Cannabidiol, being a medicine not included on the Australian Register of Therapeutic Goods, subject to the conditions set out in the approval. The schedule to the letter conformed that the treatment was for a patient described as J-ML for chronic pain. Further approvals were given on 27 June 2019 and 8 August 2019.

29. On 9 May 2019, Dr Cherukuri noted that a bone scan did not show facet joint arthritis. He was aware of the recent treatment in Shoalhaven Hospital. He said that it was necessary that Ms Longworth recover from the infection and DVT before considering surgery for axial back pain. Dr Cherukuri ordered another bone scan and MRI scan.

30. The MRI scan dated 7 June 2019 did not show discitis. At L4/5 it showed "Disc desiccation with mild loss of disc height and subtle posterior annular fissure noted. No evidence of impingement on exiting nerve roots or canal stenosis noted."

31. Ms Longworth saw Dr Ferry again on 7 August 2019. He said that Ms Longworth felt that Cannabidiol provided inadequate analgesia and that she would like to try "THC containing medical cannabis." He noted that she was about to see Dr Coghlan regarding a spinal fusion which might cause a delay in the new medical cannabis therapy.

32. Dr M Coughlan, neurosurgeon, reported to Ms Longworth's general practitioner on 29 August 2019. He noted that her worst pain was axial back pain. He said that the MRI showed very significant collapse at L4/5 and mild disc desiccation at L5/S1 and L3/4. Dr Coughlan recommended a two level lumbar interbody fusion at L4/5 and L3/4 because she had discogenic pain which had not responded to conservative treatment.

33. On 18 September 2019, Dr Ferry noted that Ms Longworth had been approved for medical cannabis with THC which was relieving her pain. He provided her with a further prescription.

34. Dr N Cochrane, neurosurgeon, was qualified by Ms Longworth's solicitors and he reported to them on 20 November 2019. Dr Cochrane said that Ms Longworth's current symptoms were:

> "The primary pain symptoms are that of low back pain. It is mid-lumbar ascending to the thoracolumbar region and is described as a band of pain and tightness across the back. Sometimes it radiates down to the sacral and coccyx region and sometimes it radiates laterally to both buttocks. It can radiate to both thighs and knees posteriorly. Back pain frequently interrupts sleep."

35. Dr Cochrane set out his observations in detail and reviewed the radiology. He said:

> "As a result of a rapid braking movement performed by·a candidate in Ms Longworth's role as a driving assessor, she has suffered an aggravation and acceleration of degenerative listhesis at L3/4 and aggravation of disc pain and facet arthropathy at the L4/5 level. Although there is radiologically a pre-existing condition, and this has been seen on X-rays in January 2017, there is no evidence provided of a pre-existing restriction.
> …
> In the material provided I can see that treating specialist, Dr Cherukuri, and Dr Coughlan have both recommended anterior lumbar interbody fusion at the L3/4 and L4/5 levels. I consider this reasonable and necessary treatment for the work-related injury being an aggravation and acceleration of pre-existing degeneration."

36. Dr Cochrane considered that Ms Longworth's prognosis was poor without surgical treatment.

37. The Department's insurer issued a notice dated 11 October 2019 denying the claim on the basis that surgery was not reasonably necessary based on the report of Dr P Bentivoglio and because Ms Longworth was reporting pain relief to Dr Ferris. It denied that the prescription of Cannabidiol was medical or related treatment because it was experimental, "nor registered" and was still undergoing clinical trials.

38. The Reply attached a letter to Dr Ferris from the Director of the Pharmaceutical Regulatory Unit of the NSW Ministry of Health dated 20 August 2019. It said that Dr Ferris had been authorised under the *Poisons and Therapeutic Goods Act 1966* to prescribe an unregistered Schedule 8 cannabis medicine. The letter warned that compliance with the conditions of the approval was mandatory. The letter said:

> "Unregistered cannabis medicines have not been assessed for quality, safety or efficacy by the Therapeutic Goods Administration, and use must be regarded both medico-legally and ethically as experimental, and patient consent obtained."

39. The Department also relied on the report of Dr P Bentivoglio, neurosurgeon, dated 4 April 2019. After setting out his findings on examination, Dr Bentivoglio said:

> "My working diagnosis in this lady is a lady with degenerative lumbar and probably cervical spondylitic disease. There have not been any MRI scans of her neck. She has axial neck and back pain. From a point of view of her lumbar spine her back pain is 8 to 9 out of 10 and her leg pain is 8/10. She does not however have any spinal canal stenosis even though she has multilevel facet joint disease. She does not have any myelopathy."

And:

> "My assessment of her current pathology is that it is an exacerbation of pre-existing degenerative disease in both regions. This is quite consistent with the mechanism of the injury. I do not believe there are any inconsistencies between the reported symptoms and her current condition."

40. Dr Bentivoglio's first report predated the first prescription of Cannabidiol. His report focussed on Ms Longworth's inability to return to work. He did not consider that her condition would improve and anticipated deterioration because of the underlying degenerative changes.

41. Dr Bentivoglio provided a second report dated 19 September 2019 in which he answered questions asked of him. With respect to surgery he said:

> "I draw your attention to my report dated 4 April 2019. At that time she had been reviewed by Dr Cherukuri a neurosurgeon who decided that conservative treatment was appropriate for her degenerative disease at L3/4 and L4/5. This, I suspect, has been exacerbated by the motor vehicle accident that she described but I feel ongoing symptoms are now related to the progression of the degenerative disease and not related to the work injury that was described on 28 March 2018."

And:

> "On reviewing her new MRI scan which was done on 7 June 2019 this shows disc changes at L3/4, L4/5 and L5/S1, with no significant neurological compression or compromise so it does not explain the symptoms of back and bilateral leg pain so I do not understand how a fusion at L3/4 and L4/5 will reasonably benefit the leg pain that she has been complaining of. The fusion at L3/4 and L4/5 may help the axial back pain from the degenerative disease but I do not see it helping the leg symptoms at all."

42. Dr Bentivoglio considered that surgery would have been required at about the same time of Ms Longworth's life regardless of the injury. He recommended persevering with alternative treatment and said that there is "no urgency for the operative intervention as there is no evidence of neurological dysfunction."

43. The Department qualified Dr J Ditton, pain management physician, to comment on the appropriateness of Cannabidiol. Dr Ditton reported on 19 November 2019. He said:

> "Ms Longworth said that she had then been referred to Dr Ferris. He had obtained approval from the TGA to prescribe a cannabinoid preparation for a period of twelve months. Ms Longworth said that Dr Ferris had recommended medicinal cannabis partly because she has been unable to tolerate any opioid medication. She said that she had initially been prescribed a preparation of cannabidiol. She said that she hadn't noticed much change when taking this preparation. She said that she had then been prescribed a combination of cannabidiol and THC (Tetra-hydro cannabinoid). Ms Longworth said that she felt better when taking this preparation. She said that when she took it at night it helped her sleep., She said that during the day it improved her sense of well-being and she had felt more able to manage her pain.

Ms Longworth said that she still wanted to have the operation on her lumbar spine. She said that she is pursuing this with her solicitor."

44. Dr Ditton was asked if the proposed use of medicinal cannabis was reasonably necessary and said:

> "It is my opinion that medicinal cannabis is reasonably necessary. However, on the basis of the available evidence it is unlikely that this treatment will reduce pain significantly or improve functional or work capacity.
>
> I note that the TGA has approved the use of medicinal cannabis for Ms Longworth."

45. Dr Ditton set out the guidelines set out by the Therapeutic Goods Administration and commented on each. He said:

> "*A comprehensive socio-psycho-biomedical assessment of the patient with CNCP is appropriate*. This has been done.
>
> *The use of medications, including medicinal cannabis, is not the core component of therapy for CNCP*; Medicinal cannabis is expected to provide minor benefits to sleep and well-being only.
>
> *Patient education is a critical component of therapy for CNCP, particularly with respect to expectations of drug therapy*. Ms Longworth has attended the STEPP program.
>
> *There is a need for larger trials of sufficient quality, size and duration to examine the safety and efficacy of medicinal cannabis use in CNCP. (p. 3)* Uncontrolled trials are not helpful.
>
> *In the absence of strong evidence for dosing and specific preparations of cannabis or cannabinoids in the treatment of CNCP, it is recommended that any treating physician who elects to initiate cannabinoid therapy should assess response to treatment, effectiveness and adverse effects after 1 month. This is best achieved as part of a research project or clinical audit. (p.14)* Dr Ferris would be responsible for appropriate monitoring.
>
> Provided that these guidelines are adhered to it is my opinion that it is reasonable for Dr Ferris to prescribe medicinal cannabis for Ms Longworth.
>
> Under these circumstances, it is also reasonable that Dr Ferris should be able to evaluate different preparations. However, preparations including THC should be monitored carefully in relation to possible psycho-active effects.
>
> …
>
> It is my opinion that any benefit of this treatment will be limited. It is unlikely that there will be significant pain relief. I note the benefits reported by Ms Longworth did not directly relate to pain reduction."

46. Dr Ditton was asked about the relevant medical literature on the appropriateness of the therapy and said:

> "I understand that the Canadian pain medicine physicians have endorsed the use of medicinal cannabis for chronic pain.

It is my opinion that since the TGA has approved the use of medicinal cannabis, it is reasonable that appropriately trained physicians should be able to prescribe the treatment provided that the TGA guidelines are followed."

47. In response to a specific question, Dr Ditton said that "Medicinal cannabis is currently not widely accepted as a treatment modality by pain medicine physicians." He considered it would "be appropriate not to introduce medicinal cannabis prior to the operation."

SUBMISSIONS

48. The submissions of counsel was recorded and I will summarise them.

49. Mr Hickey took me through the medical evidence and said that it showed that both forms of treatment were reasonably necessary medical treatment within the meaning of s 60 of the 1987 Act as discussed in *Diab v NRMA Limited*[1] (*Diab*). He noted the definition of medical or related treatment in s 59, which relevantly provides:

> "***medical or related treatment*** includes—
> (a) treatment by a medical practitioner, a registered dentist, a dental prosthetist, a registered physiotherapist, a chiropractor, an osteopath, a masseur, a remedial medical gymnast or a speech therapist,
> (b) therapeutic treatment given by direction of a medical practitioner,"

50. Mr Hickey said that the prescription of medicinal cannabis fell within both (a) and (b) of the definition.

51. Because of Dr Ditton's opinion, Mr Grant did not make any submissions about whether medicinal cannabis treatment was reasonably necessary. He did not take me to any case law. He noted that the treatment was not referred to in Table 4.1 of the SIRA Workers Compensation Guidelines dated 21 October 2019 but I observe the table deals only with treatment which can be undertaken without the pre-approval of the insurer.

52. With respect to surgery, Mr Grant noted that the consensus among the doctors was that Ms Longworth had suffered an aggravation of degenerative changes but there was no agreement as to the reason for the surgery. He said that the investigations did not support reveal a specific disc protrusion and that only Dr Coughlan had observed that there was a significant collapse at L4/5.

53. Mr Grant argued that I should prefer the opinion of Dr Bentivoglio that the surgery was likely to assist with axial back pain from degenerative disease but not leg pain. He said I should accept that there are other alternative treatments that should be exhausted.

54. In reply, Mr Hickey stressed that Dr Coughlan's opinion was based on the MRI scan undertaken in February 2019 which showed a loss of disc height at L4/5.

55. I asked counsel what order I should make if I determined that both surgery and the prescription of medicinal cannabis were reasonably necessary medical treatment. They agreed that I should make an order that allowed for both and that it was up to the medical practitioners to determine when each should take place.

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[1] [2014] NSWWCCPD 72.

FINDINGS AND REASONS

Surgery

56. Roche DP considered the meaning of "reasonably necessary" in the context of s 60 in *Diab*. He said[2]:

> "Reasonably necessary does not mean 'absolutely necessary' (*Moorebank* at [154]). If something is 'necessary', in the sense of indispensable, it will be 'reasonably necessary'. That is because reasonably necessary is a lesser requirement than 'necessary'. Depending on the circumstances, a range of different treatments may qualify as 'reasonably necessary' and a worker only has to establish that the treatment claimed is one of those treatments. A worker certainly does not have to establish that the treatment is 'reasonable and necessary', which is a significantly more demanding test that many insurers and doctors apply.
> …
> 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."

57. While Dr Cherukuri's reports do not explain why surgery will assist Ms Longworth, other medical reports do. Dr Coughlan recommended surgery after reviewing an MRI scan which he interpreted as showing "very significant collapse" at L4/5. He said she had primarily discogenic pain and failed to respond to conservative treatment. His opinion is supported by Dr Cochrane who agreed that Ms Longworth had discogenic pain and who supports the need for surgery.

58. Dr Ditton said that the structural injury associated with the aggravation of degenerative change is unclear but most probably involves discogenic pain at L4/5. His opinion is consistent with those of Dr Coughlan and Dr Cochrane.

59. Dr Bentivoglio's report was prepared in response to a series of detailed questions. He agreed that the pathology was an aggravation of degenerative changes. He described the condition as axial cervical and lumbar pain with sciatic symptoms in both legs. His report was prepared before the MRI scan on which Dr Coughlan relied. Dr Bentivoglio said that the condition would deteriorate because of the underlying degenerative disease and may need operative treatment.

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[2] At [86]-[89].

60. In his second report, Dr Bentivoglio said that Ms Longworth's symptoms were related to the progression of the degenerative disease and not the injury. That opinion is irrelevant when there is no dispute that the injury on 28 March 2018 was an aggravation of degenerative changes. A work injury does not have to be the only cause of the need for treatment before s 60 applies.[3]

61. Dr Bentivoglio accepted that surgery may be necessary. He did not consider the surgery urgent. He said that it may help the axial back pain of which Ms Longworth complains but not the leg pain. He recommended persevering with alternate treatment, including pain medication. He did not explain what the outcome of that treatment might be.

62. Dr Bentivoglio's opinion that that the surgery is not urgent fails to appreciate that Ms Longworth is required to prove that the surgery is reasonably necessary, not absolutely necessary. It does not take account of Ms Longworth's inability to take pain medication and her difficulties attending physiotherapy and hydrotherapy because of pain.

63. The bulk of the medical evidence supports the contention that surgery is reasonably necessary as a result of the injury, as explained in *Diab*. Ms Longworth has tried conservative treatment for an extended period. She continued with that treatment after Dr Cherukuri first proposed surgery without improvement.

64. I order the Department to pay Ms Longworth's s 60 expenses of and incidental to the surgery proposed by Dr Coughlan.

Medicinal cannabis

65. The Department disputes the claim for medicinal cannabis only on the basis that it does not fall within s 59 of the 1987 Act.

66. The claim is resisted on the basis that the treatment is experimental, not registered and was still undergoing clinical trials. There is no suggestion that the treatment is illegal. Mr Grant's submissions on the issue were brief and I have not gained any assistance from the reference to the Workers Compensation Guideline.

67. Mr Hickey argued that the prescription was medical or related treatment because it was treatment by a medical practitioner (sub paragraph (a)) or therapeutic treatment (sub paragraph (b)). Though the parties did not refer to it, I note that "medicines" are specifically referred to in sub paragraph (e):

> "any nursing, medicines, medical or surgical supplies or curative apparatus, supplied or provided for the worker otherwise than as hospital treatment,"

68. The prescription for medicinal cannabis was provided by a medical practitioner, Dr Ferris. They were prescribed because of the side effects suffered by Ms Longworth when she takes other medication. It was approved by both Commonwealth and NSW organisations specifically for her treatment.

69. The guidelines set out by Dr Ditton do not appear in the approvals from the TGA which appear in the file. The tenor of Dr Ditton's comments on the guidelines is that the supervision by Dr Ferris will fulfil the guidelines. His comments on Dr Ferris's role confirm the medical nature of the treatment. I am satisfied that the treatment falls within sub paragraph (a) of the definition of medical and related treatment.

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[3] *Murphy v Allity Management Pty Ltd* [2015] NSWWCCPD 49.

70. I was not taken to any definition of therapeutic. Some guidance can be gained from the definition of therapeutic use in the *Therapeutic Goods Act 1989* (Cth) is:

> ***"therapeutic use*** means use in or in connection with:
> (a) preventing, diagnosing, curing or alleviating a disease, ailment, defect or injury in persons; or
> (b) influencing, inhibiting or modifying a physiological process in persons; or
> (c) testing the susceptibility of persons to a disease or ailment; or
> (d) influencing, controlling or preventing conception in persons; or
> (e) testing for pregnancy in persons; or
> (f) the replacement or modification of parts of the anatomy in persons."

71. The treatment is, based on the evidence, therapeutic. It is prescribed to alleviate the effects of Ms Longworth's injury. Ms Longworth said that the treatment takes the edge off her pain and allows her to sleep. That is consistent with the opinions of Dr Ferris and Dr Ditton. Dr Ferris sought and was granted approval for its importation and use. I am satisfied that the treatment also falls within sub paragraph (b) of the definition.

72. The Department's reason for declining the treatment is that it does not fall within s 59 because of is experimental, not registered and is undergoing clinical trials. The meaning of experimental in this context was not elucidated. Any new treatment might broadly be described as experimental and many will later become mainstream. As Dr Ditton observed, there are appropriate guidelines to protect Ms Longworth.

73. The lack of registration is immaterial if appropriate approvals have been granted, and they have been. Ongoing clinical trials are not, of themselves, reason to exclude the treatment from the definitions.

74. The Department's objections may be reasons why, in some circumstances, treatment was not reasonably necessary but a reading of the plain words of s 59 does not prevent a relatively new treatment falling within its terms.

75. I am satisfied that the prescription of medicinal cannabis by Dr Ferris is medical and related treatment within the meaning of s 59 and I order the Department to pay the costs of that treatment.