WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3234/20**
Applicant: **Alex (Alojz) Ivanisevic**
Respondent: **Clymax Glass and Showers Pty Limited**
Date of Determination: **25 August 2020**
Citation: **[2020] NSWWCC 288**

The Commission determines:

1. The respondent is to pay the applicant's s 60 expenses of and incidental to left ankle replacement surgery proposed by Dr T O'Carrigan.

A 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.

L Golic

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

STATEMENT OF REASONS

BACKGROUND

1. Alex Ivanisevic was a working director and employee of Clymax Glass and Showers Pty Limited (Clymax) when he suffered an injury to his left foot on 24 July 2013. He was asked to measure for shower screens and mirrors in a house in Mangalore which was under construction. The only access to two of the bathrooms was by an aluminium extension ladder. When he climbed the ladder after the owner of the property, it gave way underneath him, causing him to fall. His left foot was "shattered".

2. Mr Ivanisevic has undergone many operations on his left foot in an effort to reduce pain and improve function. He has been treated throughout that process by Dr T O'Carrigan, orthopaedic surgeon. Clymax's insurer does not dispute his entitlement to compensation for medical expenses generally.

3. Dr O'Carrigan has recommended total ankle replacement. Clymax's insurer does not agree that surgery is reasonably necessary medical treatment as a result of the injury.

PROCEDURE BEFORE THE COMMISSION

4. The matter was listed for conciliation conference and arbitration hearing by video conference on 12 August 2020. Mr Hallion of counsel appeared for Mr Ivanisevic and Mr Street of counsel appeared for Clymax.

5. 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 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.

6. Clymax relied on reports from two qualified orthopaedic surgeons, to which Mr Ivanisevic objected under cl 44 of the Workers Compensation Regulation 2016. Mr Street elected to rely on the reports of Dr S Deshpande rather than those of Dr Y K Ho.

7. At the conclusion of the arbitration hearing, I told Mr Ivanisevic that I was satisfied that the treatment proposed by Dr O'Carrigan was reasonably necessary medical treatment as a result of the injury. My reasons for that decision follow.

EVIDENCE

Documentary Evidence

8. 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 (ARD);

    (b) Reply;

    (c) Clymax's Application to Admit Late Documents dated 4 August 2020.

9. There was no oral evidence. Mr Ivanisevic described the injury and the impact it has had on him in detail in his statements. With respect to the proposed ankle replacement surgery he said that he had been told by the surgeons that they cannot give a 100% guarantee the surgery will be successful and that if it does not, he will face amputation of his foot.

10. Mr Ivanisevic was taken to Wollongong Hospital where he underwent an open reduction and internal fixation of a fracture of his left navicular bone on 26 July 2013. The surgery was performed by Dr F Nouh and Mr Ivanisevic remained under Dr Nouh's care after that surgery. Dr Nouh's reports to Mr Ivanisevic's general practitioner are in the file.

11. On 9 September 2013, Dr Nouh warned Mr Ivanisevic that arthritis was a complication of the injury. Dr Nouh removed the hardware from Mr Ivanisevic's foot on 22 October 2013.

12. Dr Nouh discharged Mr Ivanisevic from his care in April 2014 but in September 2014 Mr Ivanisevic returned to see Dr Nouh because of increasing pain. X-rays showed that the fracture was united and there was no significant x-ray evidence of osteoarthritis but further scans confirmed progression to osteoarthritis. Dr Nouh recommended that Mr Ivanisevic undergo a talonavicular joint fusion and referred him to Dr T O'Carrigan.

Dr O'Carrigan

13. Dr O'Carrigan has remained Mr Ivanisevic's treating surgeon since then. He provided a detailed report dated 7 April 2020 in which he summarised his treatment since 5 November 2014. The report is a summary of Dr O'Carrigan's reports to Mr Ivanisevic's general practitioner.

14. Dr O'Carrigan noted that Mr Ivanisevic had full movement of his foot and that his talonavicular joint was not tender. The tenderness was located over the metatarsals. He said that a talonavicular fusion would result in a loss of movement and may not relieve pain. He referred Mr Ivanisevic for a bone scan and MRI scan.

15. The scans confirmed that Mr Ivanisevic required fusion of the talonavicular joint and the medial naviculocuneiform joints. On 3 December 2014, a few days before the proposed surgery, Dr O'Carrigan noted that Mr Ivanisevic has severe insertional Achilles tendinosis which was severe and characterised by a bony heel spur. While it was not specifically related to the injury, Dr O'Carrigan considered that the condition would affect Mr Ivanisevic's recovery and that it would require surgery at a later date. Dr O'Carrigan deferred the surgery to 22 December when the Achilles tendon repair could also be undertaken.

16. The wound on the Achilles tendon healed but the medial wound had failed and required surgery to prevent infection.

17. On 25 March 2015, Dr O'Carrigan noted that the joint surgery had not achieved fusion and he was concerned that, without intervention, it would fail because of persistent movement thorough the subtalar joint. Dr O'Carrigan described how he proposed to undertake the surgery. It was performed on 31 March 2015.

18. By 3 June 2015, Mr Ivanisevic had developed anterior ankle pain which Dr O'Carrigan considered may be due to impingement. He recommended an injection of the ankle joint and calf strengthening. He referred Mr Ivanisevic to Dr T Nguyen for pain management assessment and treatment. He thought that further surgery on the talonavicular joint might be required and said that wound considerations would require the involvement of a plastic surgeon.

19. Dr O'Carrigan confirmed that opinion on 15 July 2015 and suggested that aggressive surgery was required. He referred Mr Ivanisevic to Dr Q Ngo, plastic surgeon. Mr Ivanisevic was also seeing Dr Ho, a pain management specialist.

20. On 27 October 2015, Dr O'Carrigan and Dr Ngo carried out revision medial column fusion with bone graft and internal fixation and removal of implants with excision of scar and free flap. Dr O'Carrigan recommended an extended period of non-weight bearing.

21. By 9 March 2016, Mr Ivanisevic was working four hours a day. He no longer had pain at the operation site but had new pain over the first metatarsal, resulting in shooting pain when he put weight on the front of his foot. Dr O'Carrigan considered that the fusions had united. He recommended gait retraining and referred Mr Ivanisevic to Dr Nguyen again for pain management.

22. On 6 June 2016, Dr O'Carrigan diagnosed arthritis in the first tarsometatarsal (TMT) joint. He recommended that Mr Ivanisevic's footwear be reviewed but considered that it would be necessary to undertake revision surgery including removal of all of the implants to inspect the previous fusion sites and to fuse the first TMT joint. By 17 August 2016, new boots had made a "tremendous difference" and surgery was postponed but by 2 November, Dr O'Carrigan noted that Mr Ivanisevic has resumed walking with his foot externally rotated to avoid weight bearing on the medial column of his foot. X-rays showed a broken plate and screw.

23. Surgery was again undertaken on 6 December 2016 and included fusion of the first, second and third TMT joints.

24. On 1 March 2017, Dr O'Carrigan reported that Mr Ivanisevic still had pain over the first, second and third metatarsal heads and walked with an abnormal gait. Dr O'Carrigan considered that would persist long term and referred him to Mr G Williams, physiotherapist.

25. On 7 September 2017, Dr O'Carrigan noted that Mr Ivanisevic had anterior ankle pain which limited ankle dorsiflexion and forced him to walk with an externally rotated gait. He also had nerve pain on the medial border of his foot on weight bearing but also at night.

26. On 27 November 2017, Dr O'Carrigan carried out a left ankle arthroscopy and anterior cheilectomy. By 25 January 2018, Dr O'Carrigan noted that Mr Ivanisevic did not suffer ankle pain and that he was able to walk with his foot in a more normal position. He continued to suffer neuropathic pain and to be treated by Dr Nguyen. At that time, Dr O'Carrigan had not made further plans to see Mr Ivanisevic.

27. Dr O'Carrigan reviewed Mr Ivanisevic on 24 September 2019. He noted that Mr Ivanisevic had pain:

> "to the dorsum of the foot radiating to the dorsum of the ankle joint and up across the shin as well as pain down the medial and plantar medial aspect of his foot
> radiating to the medial ankle proximally."

28. Dr O'Carrigan observed:

> "On examination today he has a hindfoot that is in neutral alignment with a dorso-medial free flap that is well healed and of normal bulk. He has a stiff ankle gait with external rotation for progression angle to avoid dorsiflexion with a severe antalgic component. He has an ankle that is very stiff in range of motion with dorsiflexion to neutral and plantar flexion to 30 degrees. Ankle dorsiflexion produces anterior impingement pain. He has significant tenderness over the anterior ankle joint line with a severely positive Tinel's over the deep peroneal nerve entire distribution from the mid foot region extending all the way proximal to the ankle joint. He also has a positive Tinel's over the medial plantar nerve distribution. His deep peroneal nerve, medial plantar nerve, and saphenous nerves are essentially numb. His superficial peroneal nerve lateral branch, sural nerve and lateral plantar nerves are all normal in sensation and intact with no Tinel's sign.
>
> Alex's imaging shows ankle arthritis. There are signs of anterior impingement. His fusions have all united in a very good position and his hindfoot alignment view shows good neutral hindfoot alignment.

> My opinion is that Alex has a complex problem. He has ankle arthritis which he will require an ankle arthroplasty at some stage. He also has neuropathic pain in the distribution of the deep peroneal nerve and medial plantar nerves which I think are quite symptomatic at this point in time."

29. Dr O'Carrigan referred Mr Ivanisevic to the Limb Reconstruction Clinic at Macquarie University where he saw him with a conclave of doctors including A/Prof M Al Muderis and Dr J O'Hara, plastic surgeon. Dr O'Carrigan said:

> "Alex was sent to the Vascular Team for assessment of the pedicle location for the free flap but it is arising from the dorsal is pedis artery or anterior tibial artery proximal to the ankle. An extensive discussion was undertaken with Dr O'Hara, Plastic Surgeon, as to the best surgical approach because it is felt that the best way to approach Alex's problem is combining an ankle replacement which will deal with the ankle pain as well as deep peroneal nerve neurotomy and targeted muscle reinnervation, also considering a tendon Achilles lengthening, closing wedge osteotomy of the heel which can be done percutaneously and a tarsal tunnel release. We need to remove the screws currently passing across his subtalar joint and the anterolateral approach can then elevate the neurovascular bundle from lateral to medial and that avoids us putting the pedicle to the free flap at risk.
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> The alternative to this treatment would be amputation and Osseointegration plus TMR but Alex has got a sensate, well vascularised foot and the preference would be to keep his foot and I am sure that we can achieve a better level of pain relief and function than he currently has with that treatment approach.
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> The surgery would be done in conjunction with A/Prof Munjed Al Muderis for the TMR and the aim of this is to try to eliminate the neuropathic pain arising from the deep peroneal nerve. To that end we have arranged for a protocol specific CT scan at MMI x-ray so that we can do patient specific planning using the prophecy protocol and wright medical and that allows for the development of patient specific jigs we can use intraoperatively and increase the accuracy of insertion of the ankle replacement."

30. I understand that TMR refers to targeted muscle reinnervation.

31. A request for approval of the surgery was dated 10 October 2019 and the surgery was described as left total ankle replacement, deep peroneal nerve neurectomy and reanastomosis, removal of arthrex headless compression screws and tarsal tunnel release.

32. The surgery was booked for 15 January 2020 but Clymax's insurer declined permission. Dr O'Carrigan said:

> "The aim of this surgery was to do a Trabecular Metal Zimmer Total Ankle Replacement which involved a Lateral Approach and therefore did not require mobilisation of the free flap and combine this with surgery to the deep peroneal nerve to identify the neuroma and transplant that nerve to an area that would avoid ongoing irritation. This was to address both the arthritic and neuropathic elements to his pain."

33. Dr O'Carrigan said that the surgery was a result of the initial injury. Responding to a question as to whether the surgery was reasonably necessary, he said:

> "The Neuropathic pain from the Deep Peroneal nerve and possibly medial plantar nerve entrapment is a substantial contributor to his pain. His ankle arthritis is having a significant impact on his gait and overall pain profile. By performing the ankle replacement one can deal with the mechanical pain from the ankle joint but one must also deal with the neuropathic pain and the only way to deal with this is via the neurectomy of the Deep peroneal nerve and diversion to a non-irritant area. This would be in conjunction with the tarsal tunnel release to relieve any pressure on the medial plantar nerve cause by the aponeurosis of the Abductor Hallucis Muscle. The proposal was to do this surgery with Dr Munjed Al Muderis who has extensive experience with peripheral nerve surgery and the surgical management of neuropathic pain as a result of his pioneering work with amputees and Osseointegration. A tremendous amount of effort has been put in by Alex and his treating doctors including myself over a 7-year period and I believe this surgery has· the potential to "close off' this difficult chapter of his life so he can move forward in some degree of comfort. **Denying him this surgery is to condemn him to permanent severe neuropathic and arthritic pain and dysfunction with the only alternative being an amputation and whilst amputation and Osseointegration is an option I believe total ankle replacement and DPN/SPN neurectomy and tarsal tunnel release can achieve a better result."** (emphasis in original).

34. Dr O'Carrigan responded to the report of Dr S Deshpande, summarised below. Dr O'Carrigan disagreed that there was pre-existing arthritis in Mr Ivanisevic's ankle which was relevant to his condition, saying that it had developed beyond impingement seen in 2009 because of the work injury, surgery and gait alteration. He pointed out that ankle replacement revision rates had improved over the last 10 years and that Dr Deshpande's expertise was in hip and ankle replacements. Dr O'Carrigan said that he had performed over 130 ankle replacements and only one revision.

35. Dr O'Carrigan also noted that Dr Deshpande had identified neuropathic pain as a significant issue and explained that this was the reason for including peripheral nerve surgery as well as total ankle replacement. He described the tarsal tunnel release that is proposed to deal with the nerve pain. Dr O'Carrigan said that he had discussed amputation but considered that ankle replacement would provide a superior solution with less follow up than amputee would require.

36. Most importantly, Dr O'Carrigan said:

> "This is obviously a difficult problem but Alex cannot be left as he is and does require a solution. I believe the best solution is a total ankle replacement with peripheral nerve surgery (tarsal tunnel release and TMR) but an alternative is amputation and TMR."

37. Mr Ivanisevic relied on a report of Dr P Conrad dated 4 February 2020 who supported the need for surgery and said that it was not credible for Dr Deshpande as an insurance specialise to "go against the advice of a conclave of Australia's top specialists in the field." He said the operation needed to be done as soon as possible.

38. A report from Dr J Rowe, occupational physician, dated 23 April 2018 also appears in the ARD. Mr Ivanisevic told Dr Rowe that at that time he had 23 screws, 2 plates and 2 rods in his ankle. He continued to work part time. Dr Rowe made an assessment of permanent impairment which is not relevant. He noted that Mr Ivanisevic had been told he would require an ankle fusion. Dr Rowe considered it would be inevitable in the next two to three years.

Dr Deshpande

39. Clymax's insurer declined the request for surgery in a notice under s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* dated 23 December 2019 on the basis of a report by Dr S Deshpande.

40. Clymax's insurer relied on two reports from Dr Deshpande. The first is dated 18 December 2018. Dr Deshpande set out the history in brief form, noting that Mr Ivanisevic had undergone 13 operations. He noted that Mr Ivanisevic had been treated in 2009 for heel and ankle pain and that x-rays showed some osteoarthritis. He said that investigations showed moderate ankle osteoarthritis which was present in 2009. He said:

> "I note that the proposed surgery of ankle replacement is not as a result of the work injury.
> He had pre-existing osteoarthritis of his ankle. As far as I can tell his main symptomatology is related to the burning pain in the left foot.
> In my opinion this will not be treated by the ankle replacement.
> The results of ankle replacement are poor compared to hip and knee replacement.
> There is a high infection rate, loosening and repeat surgery in ankle replacement. It should be done for only end stage arthritis. In my opinion the x-rays of ankle do not show end stage arthritis."

41. He said:

> "When it fails, the alternative is a difficult ankle fusion or amputation .
> Considering all his symptoms of hyperaesthesia in the foot affecting the dorsum and plantar aspect of his foot which has not resolved and the multiple procedures which were complicated by infection, I would suggest an amputation rather than an ankle replacement."

42. In a further report dated 18 April 2020, Dr Deshpande said, contrasting his experience with that of Dr Conrad:

> "…I have practised as a trauma and joint replacement surgeon for the last 35 years and am now an independent medical examiner.
>
> Dr Al Meduris [sic] and Dr O'Carrigan were my registrar's while in their training and I agree they are experts in their field."

43. Dr Deshpande was asked to comment on Dr Conrad's report dated 4 February 2020 and said:

> "The proposed surgical procedures do not address the main problem which is causalgic pain in the foot which is his major complaint.
> A simple, more non-invasive procedure would be to block the peroneal and medial plantar nerves by long acting local anaesthesia to see if this relieves the pain and proceed to address the nerve pain.
> I understand that the indications for a total ankle [sic] is end stage arthritis of the ankle.
> In my opinion an ankle arthrodesis would be better than a total ankle especially when the skin around the ankle is already compromised with history of prior infection.
> I do not find any evidence of end stage arthritis in the left ankle.
> If attempts to relieve causalgia fail, then I see no alternative but to offer him a below knee amputation and prosthesis."

SUBMISSIONS

44. The oral submissions made by counsel were recorded. Mr Street handed up a written outline of submissions which remains on the Commission's file.

45. Mr Hallion said that Clymax's insurer articulated a different test to that in s 60 being whether the surgery was appropriate rather than whether it was reasonably necessary. It was clearly the case that Dr O'Carrigan and the conclave of doctors with whom he had discussed the treatment had considered the therapeutic benefit for Mr Ivanisevic. The consequences of not proceeding with the surgery were catastrophic.

46. He noted that Clymax's insurer had abandoned the argument that the need for surgery was a result of pre-existing osteoarthritis and conceded that some surgery was necessary. It argued, however, that the proposed surgery was not the best option, which is not the correct test. Mr Hallion said that Dr O'Carrigan's report was compelling.

47. Mr Street said in his written submissions that the Commission must weigh the competing views of the medical experts to determine if the proposed surgery is reasonably necessary. He said that Dr Deshpande considered that there were alternatives to ankle replacement being fusion or amputation and that amputation was more appropriate and would probably be required in the longer term as a result of complications of the replacement.

48. In oral submissions, Mr Street referred to *Diab v NRMA Ltd*[1] (*Diab*). He said that Clymax's insurer was not seeking to deny appropriate surgery but that the question was whether this surgery was reasonably necessary. If it was, there was no dispute that the cost of the surgery was appropriate.

49. Mr Street said that Dr O'Carrigan's report did not explain the alternatives. He said I should take into account Mr Ivanisevic's evidence that he was told amputation may still be required if the surgery was not successful when reading Dr O'Carrigan's firm statements.

50. Mr Hallion said that "appropriateness" was only one of the five factors set out in *Rose v Health Commission (NSW)*[2]*.* If there was some hope that the surgery would be successful it should be accepted as reasonably necessary.

FINDINGS AND REASONS

51. In *Diab*, Roche DP referred to the decision of the Court of Appeal in *Clampett v WorkCover Authority of NSW*[3], a case about home modifications, in which Grove J[4] said:

> "The essential issue is what effect flows from conditioning such qualities as 'reasonably'. The consequence is to moderate any sense of the absolute which might otherwise be conveyed by the word 'necessary' if it stood alone. In order to contemplate such moderation it is apt to consider surrounding circumstances, but the question to be addressed is whether modification of a worker's home, having regard to the nature of the worker's incapacity, is reasonably necessary. In contemplation of what might be 'reasonably necessary' there is this statutory obligation specifically to have regard to the nature of the worker's incapacity. It provides emphasis towards moderating the meaning of 'necessary' in this context."

[1] [2014] NSWWCCPD 72.
[2] [1986]NSWCC 2; (1986) 2 NSWCCR 32.
[3] [2003] NSWCA 52; (2003) 25 NSWCCR 99.
[4] At [23].

52. Roche DP said[5]:

> "The approach in *Clampett* is consistent with the modern approach to statutory interpretation, which is to construe the language of the statute, not individual words (*Sea Shepherd Australia Limited v Commissioner of Taxation* [2013] FCAFC 68 per Gordon J (Besanko J agreeing)). Thus, 'reasonably necessary' is a composite phrase in which necessity is qualified so that it must be a reasonable necessity (Giles JA (Campbell JA agreeing) in *ING Bank (Australia) Ltd v O'Shea* [2010] NSWCA 71 at [48] (*O'Shea*)). The Court, Bathurst CJ, Beazley and Meagher JJA, followed this approach in *Moorebank Recyclers Pty Ltd v Tanlane Pty Ltd* [2012] NSWCA 445 at [113] (*Moorebank*).
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> 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. ...
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> 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*[6] (see [76] above), namely:
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> (a) the appropriateness of the particular treatment;
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> (b) the availability of alternative treatment, and its potential effectiveness;
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> (c) the cost of the treatment;
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> (d) the actual or potential effectiveness of the treatment, and
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> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.
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> 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.
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> While the above matters are 'useful heads for consideration', the 'essential question remains whether the treatment was reasonably necessary' (*Margaroff v Cordon Bleu Cookware Pty Ltd* [1997] NSWCC 13; (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in *Bartolo*, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression "no reasonable prospect" should be understood, '[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content'."

[5] At [85]-[90].
[6] Referring to *Rose v Health Commission NSW* [1986] NSWCC 2; (1986) NSWCCR 32.

53. The conclusion of Dr O'Carrigan's report is compelling – Mr Ivanisevic cannot be left as he is.

54. Dr O'Carrigan provided a detailed report, setting out his thought process as to why he recommended each of the operations undertaken since 2014. He considered and explained why treatment to Mr Ivanisevic's ankle is a result of the injury. Previous treatment to the ankle was accepted by Clymax's insurer.

55. Dr O'Carrigan explained in detail why he considers that ankle replacement is the appropriate surgery for Mr Ivanisevic. After discussions in a conclave with other surgeons he has changed his mind from the recommendation of a fusion. He explained why he changed his mind.

56. I note Mr Street's submission about Dr O'Carrigan's inability to provide a "100%" guarantee that the surgery will be successful. It would be irresponsible for any surgeon to do so. As Roche DP said in *Diab*, the possibility of a less than ideal result does not mean that surgery is not reasonably necessary.

57. Dr O'Carrigan has made a recommendation but his report shows that he has carefully considered the options and the outcome. The alternatives to the proposal - including those Dr Deshpande recommends have been considered and they have been discussed with Mr Ivanisevic. He noted that amputation is an alternative but that Mr Ivanisevic would prefer to keep his leg. That is understandable.

58. Dr O'Carrigan accepted that the surgery is "unlikely to magically make him completely pain free" but could improve Mr Ivanisevic's gait and pain and allow a better quality of life. The fact that Dr O'Carrigan has undertaken 130 ankle replacements and only one revision provides a good reason to accept his statement.

59. Dr O'Carrigan's report is logical and probative, as required of evidence in the Commission.[7] He considered all of the matters noted in *Rose*, with the exception of cost which is not disputed.

60. Dr Deshpande's report is brief. His initial opinion was that proposed surgery to Mr Ivanisevic's ankle was not a result of the injury but a result of pre-existing osteoarthritis. The opinion formed the basis for the s 78 notice. It is essentially unexplained and Clymax's insurer no longer relies on it. It is contrary to the acceptance of liability for the earlier surgery to Mr Ivanisevic's ankle.

61. Dr Deshpande understood that Mr Ivanisevic's main symptomology was burning pain in the left foot. That suggests an inadequate consideration of the history in Dr O'Carrigan's reports and even of the symptoms he recorded when taking a history from Mr Ivanisevic, who described ankle pain and his abnormal gait.

62. Dr Deshpande's short but sweeping statements show that he has not considered the extent of the treatment to be undertaken. He said in his first report that "it is impossible to address" the problem of the neuropathic pain suffered by Mr Ivanisevic "by surgical means." That statement is unexplained.

63. Similarly Dr Deshpande's comments about the poor results of ankle replacement compared to hip and knee replacements are unsupported. In his second report he said that the proposed surgery will not address Mr Ivanisevic's main complaint of causalgic pain in his foot. He has not dealt in detail with the proposed TMR. Dr O'Carrigan explained that the neuropathic pain would be treated by the TMR component of the surgery, to be undertaken by A/Prof Al Muderis.

[7] Workers Compensation Commission Rules r 15.2.

64. In *South Western Sydney Area Health Service v Edmonds*[8], McColl JA said[9]:

> "In *Hevi Lift (PNG) Ltd v Etherington* at [84] I said (Mason P and Beazley JA agreeing) that '[a] court should not act upon an expert opinion the basis for which is not explained by the witness expressing it*'.* In so saying, I referred with approval (inter alia) to Heydon JA's analysis of the admissibility of expert evidence in *Makita (Australia) Pty Limited v Sprowles* (at [59] – [82]). In that case (at [59]) Heydon JA cited with apparent approval Lord President Cooper's statement in *Davie v The Lord Provost, Magistrates and Councillors of the City of Edinburgh* (1953) SC 34 at 39-40 that:
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> > '… the bare *ipse dixit* of a scientist, however eminent, upon the issue in controversy, will normally carry little weight, for it cannot be tested by cross-examination nor independently appraised, and the parties have invoked the decision of a judicial tribunal and not an oracular pronouncement by an expert.'
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> This statement is apposite in the context of Commission hearings, and, indeed, is implicitly recognised in r 70. While it must be recognised that "[t]here is no legal right to cross-examine an applicant or other witness in the Workers Compensation Commission and decisions whether to allow cross-examination or to limit it are discretionary" (*Aluminium Louvres & Ceilings Pty Limited v Xue Qin Zheng* [2006] NSWCA 34 at [37]), the fact that cross-examination of an expert witness may be permitted indicates the desirability of expert reports conforming as far as possible to common law standards of admissibility designed to ensure they have probative value. Even if that is too stringent an approach in the face of s 354, as the rules recognise, evidence must be 'logical and probative' and 'unqualified opinions are unacceptable' ".

65. Dr Deshpande's reports do not fulfil those requirements.

66. It is clearly necessary that some treatment be undertaken. I am satisfied on the basis of Dr O'Carrigan's report that the proposed ankle replacement is reasonably necessary treatment as a result of the injury in 2013.

67. I order Clymax to pay Mr Ivanisevic's s 60 expenses of and incidental to the left total ankle replacement surgery proposed by Dr O'Carrigan.

[8] [2007] NSWCA 16.
[9] At [130]-[132].