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Content:

THE INTERNATIONAL CODE OF ETHICS OF THE WORLD MEDICAL ASSOCIATION
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The medical atrocities performed during WWII were undoubtedly the most devastating for the health of survivors, all performed by medical practitioners, without the consent of the victims,-resulting in few legal prosecutions post war. The human experiences of infectious diseases such as skeletal and muscle transplantation , burns, gangrene, sulpha , atmospheric pressure , sea water ingestion, cold and heat experiences , sterilization and radiation, were all conducted without prior use of experimental animal tests. Many of them were terminal. Very few of the physicians (like Mengele, Vershauer, Schuman, Clauberg, Pokorny and hundreds more), were prosecuted, to the chagrin of the sterile, burnt or crippled survivors.

The lack of culpability was exposed with the example of Dr Sewering, who sent 900 children to Euthanasia centers for “special treatment”. Dr Sewering remained for 20 years post war as the President of the German Medical Association.

Indeed, the ultimate was his election to the Presidency of the World Medical Association. The global outcry was so loud that the doctor elected had to resign. He returned with an honorary doctor title to Munich University till the end of his life.

Established in Geneva in 1947 and London 1949, the central mission of the World Medical Association (WMA) was to ensure the highest ethical practice of the medical profession.

In the aftermath of one of the most egregious breaches of medical ethical principles, the WMA has adopted a comprehensive range of declarations, resolutions, and statements aimed at providing ethical and other guidance to the global medical profession. Several amendments since ~~in~~ those made in Helsinki, Tokyo, Sydney, etc. eventuated, the most extensive being the The International Code of Medical Ethics (ICoME) in London in October 2022.

The new Code ,in my view in no way invalidates or contradicts the old Hippocratic Oath. It upgrades and modernises the sacred Oath that should remain the basis of all Codes.

The recently accepted Code has 40 categories, all ethical obligations for physicians, namely general duties, duties to the Patient, duties to other Physicians, duties to Society, and duties as a member of the Medical Profession.

The duties of the patient toward the professional were not mentioned. They were presented by the Renaissance theologist Erasmus of Rotterdam and printed in vol.1 of the Annals of the Australian Medico-Legal College in 2021.

General Principles: 1. The primary duty of the physician is to promote the health and well-being of individual patients by providing competent, timely, and compassionate care in accordance with good medical practice and professionalism.

The physician also has **a responsibility to contribute to the health** and well-being of the populations the physician serves, as well as to society, including future generations. The physician must provide care with the utmost respect for human life and dignity, and for the autonomy and rights of the patient.

2. The physician **must practise medicine fairly and justly** and provide care based on the patient's health needs without bias or engaging in discriminatory conduct based on age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, culture, sexual orientation, social standing, or any other factor.

8. When providing professional certification, the physician must only certify what the physician personally has.

Duties to the patient: **17**. **In emergencies**, where the patient is not able to participate in decision making and no representative is readily available, the physician may initiate an intervention without prior informed consent in the best interests of the patient and with respect for the patient's preferences, where known to be verified.

26. When providing **medical care remotely**, the physician must ensure that this form of communication is **medically justifiable** and that the necessary medical care is provided. The physician must also **inform the patient** about the benefits and limitations of receiving medical care remotely, **obtain the patient's consent**, and ensure that patient confidentiality is upheld. Wherever medically appropriate, the physician must aim to provide care to the patient through direct, personal contact.

29. This Code represents the physician's **ethical duties**. However, on some issues there are profound moral dilemmas concerning which physicians and patients may hold deeply considered but conflicting conscientious beliefs.

The physician has an ethical obligation to **minimise disruption** to patient care. Physician conscientious objection to provision of any lawful medical interventions may only be exercised if the individual patient is not harmed or discriminated against and if the patient's health is not endangered. The physician must immediately and respectfully inform the patient of this objection and of the patient's right to consult another qualified physician and provide sufficient information to enable the patient to initiate such a consultation in a timely manner.

Duties to other physicians: 31. The physician should **respect colleagues'** patient-physician relationships and not intervene unless requested by either party or needed to protect the patient from harm. This should not prevent the physician from recommending alternative courses of action considered to be in the patient's best interests.

Duties to society: 35. The physician should report to the appropriate authorities conditions or circumstances which impede the physician or other health professionals from providing care of the highest standards or from upholding the principles of this Code. This includes any form of **abuse or violence against physicians** and other health personnel, inappropriate working conditions, or other circumstances that produce excessive and sustained levels of stress.

Duties as a member of the Medical Profession: 40. The physician should **support fellow physicians** in upholding the responsibilities set out in this Code and take measures to protect them from undue influence, abuse, exploitation, violence, or oppression. Physicians are facing **unprecedented challenges** brought on by and exacerbated by changing clinical, political, **legal, and market forces. T**he workgroup drafted a revised ICoME that covers the vital ethical principles and duties of physicians. These rules are mostly absorbed into the Codes of the AMA and RACS.

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PROGRESS IN THE COLLEGE SINCE 2022 .

AMLC remains a significant stakeholder in providing ongoing education of Medicolegal Assessors. Our mantra has been to provide a knowledge based legally coherent unbiased assessment for injured claimants through our educational program.

The aim is dispute resolution by:

(i) Establishing causation, that is, mechanism of injury.

(ii) Provide a comprehensive examination report.

(iii) Review of relevant investigations.

(iv) Apportionment for other accidents/conditions, be they pre-existing or later intervening event which may disrupt the chain of causation.

Because opinions vary, and claimants can present differently on occasions, we must adopt a "best endeavours" approach to consolidate the known facts into a just and fair rating, to facilitate finalising the matter.

The P.I.C. (Personal Injury Commission) was set up to amalgamate the WCC and MAA in NSW under the one body to streamline dispute resolution. This achieves a combined medical and legal process in the two arms of causation:

1. The Medical standard – the subject accident could have caused the condition or significantly contributed to the impairment that is more than negligible.
2. The Legal Standard – the subject accident did cause the injury or condition.

How do AMLC Fellows maintain their ability to adduce the evidence. They do it in several ways:

1. Assessing each claim on its merits.
2. Determining the probative material.
3. Interpreting the relevant radiology as it relates to the claimant's injuries.

4. Bullet-proof their assessments by using the appropriate guides and guidelines, for example, radiculopathy:
    - **Loss or asymmetry of reflexes**
    - **Muscle weakness anatomically aligned.**
    - **Sensory loss in dermatomal distribution**
    - Positive nerve root tension sign, example, sciatic nerve root stretch
    - Muscle wasting
    - Concordant imaging
5. Making enquiry about any discrepancy in ambulance reports, EAC notes, GP annotations and treating specialists'' opinion and where there is apparent discrepancy, being aware of it.
6. Point out any inconsistency to the claimant for clarification – procedural fairness.
7. Dating the x-rays and scans as some are pre-accident images.
8. Answering the questions posed by the Referrer.

Scarring is assessed by the "best fit" on the TEMSKI Scale (The Evaluation of Minor Scarring Impairment Scale), noting there are separate Tables for facial scarring/disfiguration.

Conclusions – by providing a Statement of Reasons: your rationale for arriving at the impairment and the basis for any deduction for pre-existing conditions.

PAIN – Although the Guidelines exclude the use of the Pain Chapter in AMA IV and V Editions, it can come into consideration:

(i) Dysthesia in nerve injury.

(ii) Tender scarring impacting on ADLs.

(iii) CRPS types I and II.

(iv) Trigeminal neuralgia.

(v) Ilio-inguinal, ilio-hypogastric, or genitofemoral neuralgia with neuromas following inguinal/groin surgery.

(vi) Occipital neuralgia, for example, cervicogenic migraine following whiplash, scalp injury.

(vii) Greater auricular neuralgia in facial pain.

(viii) Intercostal neuralgia, eg, after rib injury thoracotomy, shingles.

ANALOGY - Sometimes assessment must be made by analogous assumption, for example, a painful displaced sternal facture could be equated with a displaced sacral fracture or pes anserinus bursitis could be equated with trochanteric bursitis.

Because AMLC has Fellows from many disciplines, our forums, webinars, combined AOA/RACS/AMLC meetings allow for a cross pollination of ideas, newer treatments, devices, and implants to continually expand our expertise.

CPD HOMES - many craft groups have been instructed by APHRA to achieve 50 CPD points per annum to include:

(i) Self-education, reading journals, attending meetings and committees and roles in governance.

(ii) Develop a self-learning plan for each year that in our case is feasible for medicolegal practice.

(iii) Audit – having the IME reports assessed by colleagues or Colleges eg, AMLC, and providing first line and second line assessments for CHASM as well as attending mobility meetings.

(iv) Keep a digital logbook of ALL activities and submit them to the appropriate CPD home for central storage.

The AMA, AOA, RACS, RACP and RACGP have established CPD homes so that material can be stored for confirmation should APHRA wish to audit. This is important for our ongoing accreditation with the AMC – Australian Medical Council, to maintain Medical Registration.

AMLC is now at the stage where it can roll out sufficient podcasts, webinars, continuing educational forums and national meetings to provide medicolegal practitioners with validated CPD points going well into the future.

3. COVID, COPERNICUS AND CHROMOSOMES

Introduction: After several years of being preoccupied with the COVID-19 pandemic as a matter of unfortunate necessity, most countries have now relaxed the stringent public health measures that were designed to limit its spread. But the anti-COVID measures that were previously in force also had the effect of limiting the spread of seasonal flu, so the relaxation of those measures is now allowing this more familiar illness to return to prominence as a serious health risk in populations with reduced acquired immunity to it. [1] Hence that strange word 'influenza' is once again in the media and the public's consciousness.

Although many medical terms sound strange to the layperson's ears, influenza is strange in a different sense. It sounds familiar enough, but it is strange because it belongs, along with gout, to the relatively small class of common disease names that date back to pre-scientific medicine. 'Gout', for example, is so called because in ancient humoral medicine it was believed that inflamed joints were caused by drops (*guttae* in Latin) of corrupted humours accumulating in them. [2] 'Influenza', on the other hand, was thought to come from cosmic, rather than internal causes.

Astrology and early medicine: According to the astrological theory that was accepted throughout Europe until the scientific revolution of the seventeenth century, all celestial bodies emitted rays which could be either beneficent, neutral, or malign depending on their location in the sky relative to each other and the earth. The most important of these bodies were the stars that made up the constellations of the zodiac, the five visible planets, and the two luminary planets (the sun and moon, also regarded as planets at the time).

Each of the seven ‘planets’ had its own characteristic rays that were modified for better or worse by the emitting body’s position in relation to the other ‘planets’ and also its position in the zodiac relative to Earth, which was considered to be stationary at the centre of the universe. [3] When the configuration of celestial bodies was such that the net effect of their rays on the earth was sufficiently malign, they produced terrestrial disasters such as earthquakes, crop failures, wars, and epidemics.

These rays were described as ‘flowing’ (in Latin, *fluentia*) from the celestial bodies, so their movement of flowing inward toward Earth at the centre of the universe was collectively called in Latin *influentia*, or in Italian *influenza*. Epidemics of otherwise unknown aetiology were attributed to these ‘in-flowings’ or ‘influences’ of astral and planetary rays and hence were called ‘influenzas’, the name we still use today for certain epidemic conditions such as seasonal flu.

From this example, it’s easy to see why astrology was considered relevant to pre-scientific medicine. [4] But it was also medically relevant that the celestial bodies, in addition to causing epidemics and other widespread disasters which affected large numbers of people in roughly the same way, also had individual effects on humans that differed from one person to the next. Each of the twelve zodiacal signs was thought to be associated with a distinctive type of personality, while the five visible planets plus the sun and moon also made their specific contributions to the formation of these personality types and other aspects of a person’s characteristics. Each child, at the moment of its birth, was moulded by the collective influx of all these forces as they were configured at that particular instant.

So by assessing the precise location (as seen from Earth) of the sun, moon and planets in relation to the zodiac at the time of someone's birth, the astrologer would try to diagnose that individual's unique 'complexion' – i.e. the complex mix made up of their generic personality type as contributed by their zodiacal birth sign, and their specific individualising features as contributed by the celestial bodies at the time of their birth.

Among other things, understanding someone's unique complexion was important for knowing what the healthiest lifestyle for that person would be, what diseases they would be most prone to suffer from, what the best treatments would be for them when they were ill, and what their approximate life expectancy might be if they followed the best lifestyle for their complexion and did not meet with a fatal accident. This was quite different from attempting to predict specific events in the person's future, which was prohibited by the Church as well as by Jewish and Islamic authorities because it was seen as a denial of free will, with the ban being reiterated by the Pope in 1586. 'Predictions of fortuitous events or events depending on human will' were forbidden by the Church, but 'predictions based on nature and of use to medicine, agriculture and navigation were still permitted'. [3]

It is not surprising, then, that the study of both astronomy (which taught how to observe the celestial bodies and calculate their positions at any given time in the past or future) and astrology (which taught how to interpret the significance of those calculations for human affairs) was an important part of the philosophy and mathematics curriculum of Medieval and Renaissance universities. It was an essential preparation for students going on to study medicine afterward, and in the medical faculties themselves the specific applications of astrology to medicine were also taught.

Copernicus, a Medico-Legal Astronomer: The great Renaissance polymath Nicolaus Copernicus, whose 550th birthday occurred in February of this year, studied both astronomy and astrology as part of the liberal arts course at the University of Cracow in his native Poland. He did not take out his degree there, but instead went on to enrol in several Italian universities with the support of his uncle, a prominent bishop. At Bologna he studied civil and canon law, philosophy, mathematics, astronomy, and astrology. Next at Padua he studied medicine, astrology, law, and philosophy, receiving a medical bachelor's degree and a license to practice medicine although he did not complete a doctorate. Then finally, in 1504 he was awarded a doctorate in canon law at the University of Ferrara. [5-7]

At first glance, some aspects of his education seem strange – for example, (a) he did not take out his arts degree from Cracow or his medical doctorate from Padua after completing the relevant courses; (b) he received his law doctorate from a university where he had not studied; and finally (c) his doctorate was in canon law only, although he had also studied civil law. His decisions on these matters – or perhaps the decisions of his uncle who was paying for his education – make more sense when we note that taking out the degree after one had completed the relevant studies involved paying a substantial additional fee to the university for the award, and in the case of doctorates also paying for a public ceremony in which one defended a written thesis and then hosted a formal banquet for the professors at one's own expense.

The cost of taking out a doctorate was much greater at prestigious universities like Bologna and Padua than it was at a small university like Ferrara, and we can speculate that it would also have been greater for a doctorate in both civil and canon law than it was in canon law only. Given that

the career mapped out for Copernicus was as a canon in his uncle's cathedral, only a doctorate in canon law was required for him to enter his career, although he certainly had to make use of his knowledge of civil law as well. So, it seems likely that financial considerations governed his choice of degrees.

As a canon, Copernicus took minor ecclesiastical orders but was not an ordained priest, so he did not require special permission to practice medicine. Therefore, he was able to become the physician to the Cathedral Chapter (the group of clergymen attached to the cathedral, including his uncle the bishop). In addition, he was centrally involved in the administration of the cathedral and its properties in accordance with canon law, and he served as the cathedral's legal officer in its dealings with the civil authorities. So, it was his practice in the professions of medicine and law that gained him a living – his astronomical research was a spare-time activity. [8]

A contemporary of Copernicus reported that he was 'intimately familiar with the practice of astrology', [8] although there is no evidence of Copernicus ever having practiced as an astrologer in the sense of casting horoscopes or issuing prognostications. A manuscript medical treatise exists, written in Latin and attributed to Copernicus, which does refer to astrological considerations in connection with various remedies that it recommends, but the attribution to Copernicus is generally agreed to be a forgery. [7] Nevertheless, the manuscript indicates the kind of medical environment in which Copernicus practiced, so it is most probable that in his medical practice he would have acted in conformity with the relevant astrological doctrines because his patients would have expected it and his professional reputation would have depended on it.

A First Step: It was after he returned from Italy to Poland that Copernicus completed the first step of the scientific revolution for the physical sciences with his astronomical treatise, *Six Books on the Revolutions of the Heavenly Spheres*. This work was published in 1543, the year of his death. [9] In it he introduced the concept of the 'solar system' in which the planets (now including Earth) orbit around the sun, to replace the system of the universe inherited from the ancients in which the sun, moon and planets orbited around a stationary earth.

Important though this first step was, the only parts of Copernicus' doctrine which modern astronomy retains today are (a) that the sun is not a planet, (b) that all planets orbit the sun, (c) that the earth is a planet which moves in various ways, including a daily rotation on its axis, and (d), that the moon is not a planet but a satellite orbiting the earth. The rest of Copernicus' astronomical views have all been left behind – including such important matters as the position and immobility of the sun, the number of planets in the solar system, the shape of the planetary orbits, the cause of planetary motion, and the finite size of the universe.

If we look at Renaissance medical astrology in the same way as Copernican astronomy, we can see that from the perspective of modern medicine, this astrological doctrine was also an important first step. Astrology claimed that at a decisive moment in the formation of each individual, (their birth), the precise configuration of a number of variables (the stars of the zodiac and the planets) established that individual's general personality type, strength of constitution, approximate life expectancy and predisposition to future diseases. Moreover, these characteristics of the individual could in principle be specified in detail if one had enough information about a person's formative variables. The manifestation of these characteristics as the individual

developed was of course open to modification by the person's lifestyle, environment, and experiences, but the outer limits of any potential for modification were set by the individual's specific astrological endowment.

Today we retain these beliefs, but we have 'internalised' the aetiological process by locating it not in the cosmos but in the organism, transferring it from astrology to genetics. We now regard the decisive formative moment for each individual as conception rather than birth. And we identify the configuration of variables with the recombination of parental chromosomes in the gamete, rather than with the movement of celestial bodies in the skies. But in general terms, we accept the astrologers' proposition that each individual is initially endowed with a determinate nature that broadly governs personality type, strength of constitution, approximate life expectancy and predisposition to future diseases. And we also hold that these individual characteristics could in principle be specified in detail if one had enough information about a person's genetic makeup. Like astrological characteristics, the expression of these genetic characteristics is subject to a degree of modification by lifestyle, environment, and experiences. But genetic endowment defines the outer limits of an individual's future potential for development.

In spite of these parallels, there is an important difference between the 'first step' Copernicus took and the one taken by the astrologers. In the physical sciences the modern understanding of the solar system, although radically different in many respects from the one proposed by Copernicus, can be seen as having descended from the initial Copernican insights published in 1543. Our modern understanding is the work of successive generations of physicists and astronomers who followed after Copernicus, discarding the parts of his system that they found inadequate and introducing new features, but still working on the project that he inaugurated.

In the biomedical sciences, however, the principles of astrology and genetics that were shown above to be analogous, do not seem to be related by any traceable historical line of development. Nevertheless, the basic logic of explanation for human characteristics that astrologers first worked out is the one that genetic theory now employs, even though genetics reached this point independently and not by successive reworkings of astrological theory. Most Renaissance astrological beliefs, like most Copernican doctrines, have been left behind by modern science. But the fundamental underlying assumptions of the astrologers concerning the formation of individual human characteristics still have a place in modern biology and medicine.

References:

1 WHO Western Pacific. Influenza and COVID-19: Five Tips for a Safer Winter. 25 November 2022. https://www.who.int/westernpacific/news-room/feature-stories/item/influenza-and-covid-19--five-tips-for-a-safer-winter (accessed 8 February 2023)

2 Porter R, Rousseau GS. *Gout, The Patrician Malady.* New Haven: Yale UP, 1998, p. 14

3 Department of History and Philosophy of Science, University of Cambridge. Astrology. http://www.sites.hps.cam.ac.uk/starry/astrology.html (accessed 8 February 2023)

4 Pfeffer M. Before Epidemiologists Began Modelling Disease, It Was the Job of Astrologers, *The Conversation*, 19 May 2020. https://theconversation.com/before-epidemiologists-began-modelling-disease-it-was-the-job-of-astrologers-137895 (accessed 8 February 2023)

5 Department of History and Philosophy of Science, University of Cambridge. Nicholas Copernicus (1473-1543). http://www.sites.hps.cam.ac.uk/starry/copernicus.html (accessed 8 February 2023)

6 Department of History and Philosophy of Science, University of Cambridge. Copernicus and Astrology. http://www.sites.hps.cam.ac.uk/starry/coperastrol.html (accessed 8 February 2023)

7 Rutkowski B et al. Nicolaus Copernicus: Not Only a Great Astronomer but Also a Physician. *Journal of Nephrology* 2011, 24(Supplement 17): S25-32

8 Westman RS. Nicolaus Copernicus, *Encyclopedia Britannica* online. https://www.britannica.com/biography/Nicolaus-Copernicus (accessed 10 February 2023)

9 Copernicus N. *De Revolutionibus Orbium Coelestium Libri VI*. Nuremberg, 1543

ONE DOCTOR'S EXPERIENCE WITH HEALTH CARE COMPLAINTS COMMISSION (hccc).

After 50 years of practicing medicine in a variety of roles including some years as a Country GP/Surgeon, I have inevitably had many stressful experiences. Of these there has been involvement in two police sieges and having a pistol pointed at my head. Of the purely medical stressful situations, the most notable was being faced with a footling breach presentation with maternal and foetal distress many miles from a base hospital. Mother and baby survived without mishap.

These and many other situations have given rise to great anxiety. However, all have paled into insignificance compared with my experience with HCCC. The case concerned a woman who worked as a nurse's aide for 13 months at a care home in 2006-7. She claimed an unwitnessed right shoulder strain after being in the job for six months. She completed the rest of her shift without notifying her employer.

Three days later she saw her GP having worked normally for the intervening 2 days and was given a Workcover Certificate for two weeks. At the end of this period had a final certificate, "fit for normal duties".

Over the next seven months she made no further complaints to the employer about her shoulder and did her normal duties until claiming an injury to a finger. She continued her normal duties for the following two weeks prior to going off with a Workcover Certificate, stating that her injured finger made her unfit for work. She then went overseas. During the next nine years she spent some time in her homeland. She claimed she had had no employment and said the reason for this was that she was suffering from multiple conditions caused by the 13 months she worked in the Care Home.

Nine years after her leaving work I did an independent, forensic, based, medical assessment. The clinical examination found no objective or subjective abnormality which could explain her ongoing multiple and increasing symptoms affecting seven different regions of the body but not the finger which had caused her to cease work 9 years earlier.

During the examination, she exhibited many inconsistencies. This clinical evidence led to the conclusion that she was a fit and healthy 57-year-old woman and that any injury that she may have sustained during her employment had long since resolved.
The investigations showed no evidence of underlying significant symptomatic pathology.

In the 2 hours she was in the rooms, the claimant made no complaint to the examiner or to the receptionists. They commented that at no time did she exhibit any sign of unusual anxiety, anger, or stress, despite going through the waiting room on 3 occasions. Neither did she make any complaint about the examiner's behavior to her general practitioner, her psychologist or to any other person in authority.

Only on receipt of the examiner's independent medical report four weeks after the examination did she write a letter of complaint to the Medical Council, the police and HCCC. This letter described how she was subjected to a very unpleasant examination which included the examiner partially undressing himself and inappropriately touching her. She wrote that she was so upset that she cried all the way home and was very distressed.

I refuted all these claims, I had just done my job without fear or favor. As there was a sexual component to the complaints, I had to attend a day at a Section 150 hearing of the Medical Council.
Their decision was that I was allowed to **continue to work without any restrictions**.

In addition, I was effectively formally arrested by the police prior to undergoing a prolonged interview. The result of which was that the police considered that I had no case to answer and that **I could continue with my work without restriction or further investigation**.

The Medical Council automatically sends the proceedings of any enquiry to HCCC.

Over the next 3 years, HCCC pursued this complaint against me. In doing so they interviewed the claimant, and a further new letter of complaint was produced.
What became clear was that issues mentioned in the Section 150 hearing (the claimant had not been present) were now placed in this new amended letter of complaint.

An example of this concerned a gauze dressing. I had explained at the Section 150 hearing that the dressing was placed over a stitch abscess (previous abdominal cancer surgery). Reference to her having seen the gauze appeared in the new allegations but it was now situated over the sternum.

In addition, this new letter contained more lurid complaints of a sexual nature against the examiner. It should be mentioned that the claimant made a hand-written acknowledgement of the help given to her by two of HCCC's personnel who came to her home and enabled her to formulate the new letter.

The inference perceived from this new letter, is that the examiner was seeking sexual gratification from the claimant because his wife was "old".
Despite the examiner writing a full rejection of these new complaints, 3 years and 3 months after the examination, 4 days were set aside within the District Court for a hearing before a Tribunal. The members of this consisted of two medical practitioners, a lay person (a psychologist) and presided over by a Judge of the District Court.
HCCC had, as their expert witness, a general practitioner who had no specialist knowledge of independent medical examinations of compensation claimants.
His comments alluded to the second letter of complaint rather than the original.

All the claimed allegations of the examiner's overtly sexual behavior were withdrawn by HCCC early on day 3 of the hearing as they had been shown under cross examination during the proceedings, to be a fabrication.
Without these allegations, the Tribunal hearing would not have occurred.
This means that logically I should have had no adverse finding against me.

The judgement was finally delivered 4 months later. This stated that I was reprimanded for not leaving the examination room when the claimant removed her trousers. This allegation was not in the original letter of complaint.When asked if I had left the room, I had answered truthfully that I probably would not have done so in 2016. By her own admission, under oath, she was wearing a knee length tunic dress over her trousers. There is no appeal process available to practitioners.

What resulted from this prolonged very traumatic experience?

1 The claimant's allegations negated my report. A report written in 2017 by a specialist, after a referral from her lawyer, determined that she had a 20% whole

person impairment, all due to her 13 months employment at the care home in 2006 to 2007. This report had no forensic component and accepted all her stated symptoms as totally genuine. The 20% WPI gave her $37,000 and an excuse to avoid the need to seek new employment.
2 My practice suffered because I was considered a risk (no smoke without fire). The insurer who had referred the case to me and who had been prepared to wait for 6 weeks whilst I was recovering from major surgery, to see this "difficult" claimant (their assessment of her), ceased sending referrals to me.

3 The financial cost to the taxpayer and the medical defense insurer of this vexatious complaint, has been estimated to be in the order of more than $250,000.
It is reasonable to conclude from my experience and from colleagues who have undergone the experience of defending other unjustified proceedings, that HCCC have an agenda to pursue the "victim's" complaints, even in the face of clear evidence to the contrary.

The concept of **'innocent until proven guilty'** does not seem to apply.

In this **age of blame**, this approach is to be expected but should not be condoned by those politicians who have charge of HCCC, and similar statuary bodies.

STRESS CLAIMS IN THE COMPENSATION CASES .

The old timer shows the new guy how to work the system. Before you go in for treatment or evaluation, don't shave for three or four days. Wear old fatigues, some unit patches, an old beret. Study the symptoms of PTSD. A.Hurst,

PTSD is the only psychiatric illness people want to have. Nancy Andreassen

Problems encountered with psychiatric claims: Unlike law, psychiatry sees the provision of service to the client in terms of clinical responsibility, at times involving roles of advocacy or intervention which is quite foreign to the practice of law, especially in the adversarial system.

- Psychiatric diagnoses are constantly evolving under the influence of new research and statistical techniques. Despite the belief that diagnosis is instinctual, random, and esoteric, diagnostic reliability between psychiatrists on major disorders, like psychosis and organic brain damage, is relatively high with a range of 60% to 70% — which compares well to conditions like cardiac failure.
- With the less severe conditions, diagnostic reliability decreases and is probably lowest (30%) for personality disorders.

The Elastic Concept of Stress: Stress is a term that has multiple meanings, including social, cultural, medical, and scientific. It remains a word that makes psychiatrists uneasy since it cannot be operationalized but defined by its effect on a person. Some examples of the varying definitions: Physiological stress: An organism's response to a stressor such as an environmental condition. Hans Selye: the hypothetical non-specific response of an organism to stressors.

- Surgical stress: A response to surgical injury characterized by activation of the sympathetic nervous system, endocrine, immunological and haematological changes.

- Psychological stress: The response to an external event that is disturbing, frightening, (potentially) harmful or poses an existential threat to the individual.

Assessment of the *psychological* response to stress goes back at least 150 years in response to two events: the American Civil War and the development of the railways.[i] In the first event, combatants developed 'Soldiers Heart' or da Costa's Syndrome, which led to the later diagnosis of neurasthenia. Beard defined this condition as arising from exhaustion of the nerves with symptoms of tiredness, anxiety, depression, neuralgia, hypertension, and palpitations.

With the railways, survivors of accidents, often quite minor, developed a range of symptoms such as paralysis, to be known as Railway Spine. It was postulated that they had developed microscopic spinal changes, similar to whiplash.[ii] In the debate which followed, alternate explanations were hysterical conversion (eg., Jean-Martin Charcot) or (especially from the railway owners), malingering.

This set the tone for the debate in medical, scientific, and legal circles which continues to the present day.

The diagnosis and treatment of stress assumed dramatic proportions in World War 1. While the physical casualties were huge, no one had anticipated the psychiatric cases that developed in men exposed to the relentless shelling, gassing, and killing in the trenches. This became known as *shell shock* and led to fierce debates as to its cause and treatment. An early school of thought suggested a form of concussion, caused by explosions or gassing. Alternately, such patients were constitutionally weak (degeneration theory), they were unwell previously, or simply malingerers (with brutal means used to 'shock' them back to fitness). Finally, the psychoanalysts felt the soldiers had

reactivated infantile traumas – which at least led to a more humane approach to treatment.

During World War 11, the situation did not change much. The German military medical corps simply eliminated the diagnosis and were not permitted to diagnose it; the Russians were no better. On the Allied side, the term Battle or Combat Fatigue was used as an alternative. These cases often presented with gastro-intestinal symptoms, showing how the clinical picture had changed regardless of the cause.

After the Viet Nam War political, social, psychological, and cultural pressures came together. In response to the “Viet Nam Veterans’ Syndrome” – veterans who could not settle back to civilian society, used drugs and drank, had outbursts of temper and violence and would experience nightmares and flashbacks – the influential VN Veterans’ Association lobbied for acceptance of the condition. This played a significant part in the DSM-111 categories of Acute and Post-traumatic Stress Disorder (PTSD). Important as it was to recognise the problems experienced by the veterans, it has become an index case of how a diagnosis has been made by a committee driven by non-scientific and highly political issues to make its findings.

Post-traumatic Stress Disorder (PTSD): The concept of PTSD arises from the legal concept of 'nervous shock'--a sudden event causes an acute emotional turmoil which is the cause of subsequent psychiatric illness. Acute Stress Disorder (symptoms only in the first four weeks) has had an unstable life, being eliminated in DSM-1V, then resurrected in DSM-5TR.

PTSD is unique among psychiatric diagnoses because it assumes that the cause of the disorder is known – it is the result of *trauma* – and here lies an etymological problem: how is this defined? The current definition of PTSD is

that a traumatic event (or series of events) should involve ‘actual or threatened death or serious injury’ (DSM–IV) or be of ‘an exceptionally threatening or catastrophic nature’ (ICD–10). Furthermore, the reaction to the event should be likely to ‘cause pervasive distress in almost anyone’ (ICD–10) or involve ‘intense helplessness, horror or fear’. This must meet the requirements of Criterion A: an 'event, which lies outside the normal pattern of human experience, and which would clearly cause suffering in virtually everyone'.

PTSD used to be regarded as a condition arising from severe trauma in the military sector, with another group being those who survived concentration camps or bombing of cities, but it has now extended widely into the civilian sector. Childhood abuse; motor accidents; and aggressive, hostile or confronting situations in the workplace. Examples that strain the definition to its limits include the removal of a wisdom tooth, giving birth to a healthy baby and being the recipient of sexual jokes at work.

A rebarbative recent addition to the accepted causes is ‘bullying’. While there may be a legal definition, claimants claim issues such as performance management, arguments, not getting promotion or being required to transfer. It strains credibility for the assessor to make a distinction between the usual exigencies found in any job and ‘bullying’. This is not helped by the common occurrence of submitting a claim after an adverse performance review and retrospectively claiming months or years of bullying that had never been raised before. Exposure to a traumatic stressor produces PTSD in only a minority of victims.[iii] If the current formal criteria for a traumatic stressor are applied, then an inhabitant of the USA would have a 40+% lifetime risk of being exposed to a traumatic event. Significantly, only a minority of these will go on to develop PTSD.

However, although nearly everyone can be expected to experience distress from various types of trauma, it is axiomatic from numerous studies that PTSD does not develop in everyone exposed to trauma, no matter how severe. A controversial issue is vicarious experience of trauma, eg., through medical, police or counselling work.

Epidemiological studies show that the development of PTSD is associated with a history of childhood behavioural problems, parental divorce, poverty, physical abuse, and current unemployment and even a genetic predisposition – just like other neurotic disorders; previous traumas increase the risk. Probably a history of psychiatric illness is the only valid predictor. It is doubtful whether a single post-trauma syndrome exists across all cultures, and in response to all traumas. The boundaries between PTSD and other psychiatric syndromes that become manifest after adversity are blurred – commonly a mixed anxiety-depressive condition. PTSD is also not the only, or even the most common, psychiatric sequela of trauma and is rarely found on its own.

PTSD is the psychiatric disorder most likely to be involved in compensation claims because by definition it arises from the external event that allegedly causes the symptoms.[iv] The explosion of claims after the publication of DSM-111 caused great controversy and has been labelled as a pseudo-epidemic, heavily driven by financial, social and media factors. On the other hand, those who support the claimants in these cases accuse workers who question the validity of claims of bias or prejudice indicating the adversarial nature of the debate.

The influence of litigation on disability cannot be dismissed. What is missing is any understanding of the problem of social reinforcement and iatrogenesis on chronic psychiatric disability. The empirical evidence shows that symptoms do

not resolve after litigation, but also suggests that litigation may be bad for the claimant.[v] Once embarking on litigation there are no rewards for getting better - rather the reverse.

PTSD is a tightly defined psychological disorder. It has a relatively low prevalence, in keeping with the tight definition. Discredit is brought to experts, and to the profession generally, when PTSD is imprecisely diagnosed. This additionally fails to assist the legal process. The problem with making the diagnosis is the need to rely on the patient's account of the trauma and how they reacted at the time.

Historical studies over the last 150 years have shown that (1) symptoms vary considerably over time, circumstances and in individuals; (2) the mode of presentation, illness behaviour and prognosis is considerably affected by prevailing attitudes, as well as those of the treaters involved. This explains why social and cultural factors play such a part in the presentation of the condition.

Critical to understanding how the controversy arose is the dispute over the reporting of PTSD by US Vietnam veterans. It would be expected that the highest incidence of PTSD occurs at the time of the traumatic event (or events). However, there was a relatively low rate of diagnosis of combatants while in Vietnam. After the war ended, the rate of complaints escalated steadily, rather than waned. This led to a review of claims (it must be said that these results were intensely disputed) showing that the *actual rate* of PTSD was far lower than indicated by the claim rate and *a significant number of claimants had not been involved in combat situations;* in some cases, they had not even left the USA.

Following exposure to similar traumatic events, there is a wide variation in the rate of PTSD. Studies relating the frequency of flashbacks to the occurrence of

nightmares differ between civilians and combat veterans. For example, the rate of PTSD following exposure to earthquakes varies from 3% to 87%. PTSD is reported to occur in 15–30% of persons involved in motor accidents, and in up to 80% of rape victims.

In this regard, there has been much discussion of the effect of the 9/11 bombings on those who viewed it on television, leading one writer to comment (ironically) that it could consist of ‘‘*PTSD of the virtual kind*’’. A flood of therapists descended on New York in anticipation of treating local citizens, yet studies showed minimal, if any, cases arose – probably due to the shared adversity response found in wartime when the suicide rate drops. Abundant evidence points to the increased risk of other disorders arising from traumatic injury.[vi] Depression, a common response, occurs frequently 6–12 months post-injury, with rates from 6-42%. There are significant rates of generalized anxiety disorder (10%), agoraphobia (7%), social phobia (5%), panic disorder (4%), and obsessive–compulsive disorder (2%).

The publication of DSM led to what was called a “*tick-box” approach* by examiners who would use a simplified questionnaire. This approach, putting great emphasis on nightmares, flashbacks and the startle reflex, discouraged clarification of these features, ignoring the mode of examination intrinsic to psychiatric assessment, the evidence of great individual variation and documentation in the literature that other psychiatric disorders had similar or overlapping symptoms. A typical example is confusing context-specific nightmares with sleep paralysis, which is non-specific and occurs widely with a range of causes.

Paul McHugh sums up the issue: *Previously, bottom-up diagnosis was “based on a detailed life history, painstaking examination of mental states, and*

coordination from third-party informants." Top-down meant cursory reliance on symptom checklists. "The manual promotes a rote-driven, essentially rule-of-thumb approach".[vii]

Characteristic of the current explosion of claims is *Service Institutions* – notably military, police, fire brigade and correctional services which raise the epistemological problem that dangerous work or distressing events are an expected and regular part of the job.

1) *Bracket Creep* – a constant push to extend the criteria to situations that would be regarded as either casual or unrelated issues, mostly workplace disputes over promotions personality clashes or disputed transfers become merged with a list of traumatic events used to justify the claim. [viii]
2) The *Dose Response theory* – otherwise known as the Stress Inoculation hypothesis, namely the PTSD occurs on a quantitative basis. See below.

Common psychiatric comorbidity with PTSD: Dissociative disorders, Dysthymia, Eating disorders, Depressive disorder, Mania, Anxiety disorders, Personality disorders, Somatization, Substance abuse (alcohol and illicit drugs).

FAVOURING / OVERUSE OF THE CONTRALATERAL LIMB

Assessing "favouring" (overuse) of the contralateral limb requires:

- Basic concepts of causation
- Basic concepts of apportionment
- General concepts of levels of evidence
- Research evidence re causation of the claimed contralateral limb diagnosis.
- Research evidence re: Can favouring cause overuse of a contralateral limb?
- A detailed history of this claimant's post-accident activities

AMA Guides to the Evaluation of Disease and Injury Causation, 2nd Edition, 2014

- 53 Contributors & 29 Reviewers, many of whom were Editors, Contributors and/or Reviewers of 5th and 6th Editions of *AMA Guides to the Evaluation of Permanent Impairment*
- 3 of the 4 Editors were Editors, Contributors and/or Reviewers of AMA 5 & AMA 6
- Available from Australasian Medical Publishing Company
- Thousands of references including systematic reviews, meta-analyses, prospective studies and randomised control trials
- All quotes are from these *Causation Guides* but are kept in context and summarise the final position of each section of the book.
- All emphases in the quotes are mine

Poor Quality Research (p 105): "Causation of musculoskeletal disorders has been controversial, in large part owing to the voluminous quantity, but relatively poor quality, of the epidemiologic literature...

- There are few prospective cohort studies, samples are small, exposures are rarely well measured, biases are typically common, and confounders are generally only partially controlled. "This contrasts with the extensive large-scale prospective studies of cancers and cardiovascular disease.

Specific Terms Used in these Causation Guides (p 117): Very strong evidence

- Strong evidence
- Some evidence
- Low risk evidence
- Insufficient evidence
- No risk evidence.
- Not studied

Upper limb disorders in Causation Guide: Evidence is assessed for the following risk factors:

- Non-occupational factors: Age, BMI, gender, biosocial factors, diabetes, smoking
- Highly repetitive work alone or combined with other factors.
- Forceful work
- Awkward postures
- Combination of risk factors (force + repetition, force + posture)
- Keyboard activities
- Length of employment
- Vibration
- Cold environment
- Dominant hand

Carpal Tunnel Syndrome: Very strong evidence of many Non-occupational risk factors (p 283): Comorbidities (OA, rheumatoid, wrist #): Very strong evidence

- Thyroid disease: Very strong evidence
- Diabetes: Very strong evidence
- Gender (↑ in females): Very strong evidence
- ↑ age: Very strong evidence
- ↑ BMI: Very strong evidence
- Genetic: Very strong evidence
- Biopsychosocial factors: Very strong evidence
- Gardening and knitting: Some evidence.
- Carpal tunnel or wrist size/ratio: Some evidence
- Smoking: Low risk

Carpal Tunnel Syndrome: Occupational risk factors (p 282):

- Keyboard activities: Insufficient evidence
- Forceful work: Very strong evidence
- Combination of risk factors (intensive force + repetition &/or posture), meat/poultry, car assembly: Very strong evidence
- Highly repetitive work alone: Highly conflicting evidence
- Job satisfaction: Some evidence
-
- Awkward postures: Low risk evidence
- Vibration: Low risk evidence
- Length of employment: Insufficient evidence
- Cold environment: Insufficient evidence

SHOULDER Tendinopathy, Impingement, Rotator Cuff Tears (p 320)

Evidence of NON-occupational risk factors: ↑ age: Very strong evidence

- Biopsychosocial factors: Strong evidence
- ↑ BMI: Strong evidence
- Diabetes: Some evidence
- Anatomy: Low risk evidence
- Comorbidities: Insufficient evidence
- Gender: Insufficient evidence
- Genetic: Insufficient evidence
- Dominant hand: Insufficient evidence

SHOULDER Tendinopathy, Impingement, Rotator Cuff Tears (p 320)

Occupational risk factors: Forceful work alone: Insufficient evidence

- Awkward postures, sustained shoulder postures with >60° flexion or abduction: Strong evidence
- Highly repetitive work: Some evidence
- Combination of risk factors (force + repetition; or force + posture): Some evidence
- Length of employment: Insufficient evidence
- Keyboard activities: Insufficient evidence
- Vibration: Insufficient evidence

Lateral and Medial Epicondylitis (p 275): Keyboard activities: Insufficient evidence

- Highly repetitive work: Insufficient evidence
- Forceful work: Low risk evidence
- Awkward postures: Low risk evidence
- Combination of risk factors (force + repetition, force + posture): Strong evidence
- Length of employment: Insufficient evidence
- Vibration: Insufficient evidence
- Cold environment: Insufficient evidence

APPORTIONMENT

Principles of apportioning causation: "Probable causes are included in the apportionment, but possible causes are not" (p 140)

  - Similarly, AMA 6 (page 609): "Only probable causes (at least more probable than not) are included".
  - "Post hoc ergo propter hoc": The sun always rises after the cock crows, ∴ the cock causes the sun to rise.

- First consider all potential causes… congenital, genetic, constitutional, lifestyle, prior trauma, subsequent trauma, & subject accident (p 140)

Definition of probable cause (p 760):The *proven* Dx could have been caused by the work/MVA/fall etc, and

- There was sufficient magnitude of trauma at work/MVA/fall, and
- In this claimant, the specific evidence supports a work/MVA/fall cause rather than a non- work/MVA/fall cause.
- "2 or more *possible* causes do not equal 1 *probable* cause" (p 760)

When recording apportionment, a physician must (p 147):

- "…also provide the *basis* for that opinion… The opinion of an expert is no better than the reasons upon which it is based."
- Explain reasoning (pertinent facts, history, examination, and science)
- Not be speculative.
- Apportion "…with reasonable probability, not possibility", ie 51+% certainty

However: "When apportioning impairment of a body part or organ system, any pre-existing rating is subtracted from the current percentage to obtain the net impairment due to the injury or disease in question." (p 144)

- ∴ not shared, but fully subtracted.

FAVOURING: The **favouring → overuse** hypothesis (p 758): "… healthcare professionals and scientists cannot credibly rely on superficial considerations of plausibility or intuition. A solid basis in science is required instead.

- This article provides a review of the medical literature and, in so doing, reveals that there are no credible studies that support such a causative relationship."
- "The concept that favouring one upper limb can result in injury or illness in the other is not based on scientific evidence; instead, it is an unsupportable myth." (p 758)
- Scientific research indicates "activity and use actually promotes health", not injury (p 758)
- The source of the claimed temporal sequence is usually the patient, but "scientific findings repeatedly demonstrate that patient-reported histories are extremely unreliable" (p 761)
- "This scenario is not supported by the literature. In fact, most persons have a significant decrease in total activity because of the first injury or illness. Most persons alleging this mechanism of injury are already on major work restrictions and thus, either doing a different and easier job or off work, alleging they do very little at home." (p 761)

- "The incidence rate for favoured upper limb onset is not significantly higher than the incidence rate for the dominant side, as would be expected in this situation of assuming the cause is due to overuse." (p 762)
- Much of the literature suggests that the contralateral uninjured or asymptomatic limb at the time of the initial… injury… is usually not normal but has already developed some disease. Therefore, the development of the condition on the initially uninvolved contralateral side is more probably related to individual risk factors such as genetics, age and sex, rather than overuse." (p 762)
- Carpal tunnel syndrome: "Idiopathic carpal tunnel syndrome is commonly bilateral (87% of cases in Padua's series), and it is difficult to prove that symptoms that began on one side caused similar ones in the other." (p 763)
- Shoulder conditions including rotator cuff: "…the articles reviewed do not support 'favoring' as a reasonable cause of development of symptoms in the contralateral shoulder… There is no scientific support for the concept that having symptoms in the first limb causes an increased rate of disease in the second limb." (p 766)

Favouring the contralateral UPPER limb: Epicondylitis: "The British Systematic Review of upper limb (and elbow) tendinitis and tendinopathy did not find evidence to attribute the development of elbow tendinitis to ergonomic exposures." (p 766)."Currently there is insufficient evidence to support *'favoring'* as a probable cause for symptom onset in the originally uninvolved elbow." (p 766)

Favouring the contralateral LOWER limb: "… the forces and number of loading cycles on the unaffected [lower] limb are likely to be *less*, not higher, than before the original injury or illness."

- "…someone with lower limb pain typically walks slower… shortens his/her stride length", and takes less steps per day (p 771)
- "Review of the medical literature reveals no generally accepted studies that support such a causal relationship, nor is there any reasonable scientific logic therefor" (p 770)
- Specifically, gait studies indicate NO pain in the contralateral limb from:
  - Antalgic limp
  - Paralytic limp
  - Short-leg limp less than 4cm shortening.
  - Use of a cane or crutch(es)

In summary, the scientific evidence indicates that injury of the opposite limb from 'favouring' *"is an unsupportable myth".*

A CASE OF CERVICAL MYELOMALACIA

Myelomalacia is a pathological term referring to the softening of the spinal cord. Causes include cervical myelopathy, haemorragic infarction or acute injury, such as that caused by intervertebral disc protrusion.
It is usually diagnosed by Magnetic Resonance Imaging (MRI).

A Case of Traumatic Myelomalacia

Mr VD was a Fire Fighter involved in three injuries over the years.
January 2011, a bag of equipment fell onto his head, causing significant neck and left arm pain. Attention was concentrated on the left, non-dominant shoulder, investigations uncovering no local pathology.

January 2022, required to sweep over a 500-metre stretch of road after diesel spill, significantly increasing left shoulder pain. On 17.3.2022 an X-ray of the left shoulder showed a normal study. On 25.3.2022 MRI scan of the left shoulder identified no significant pathology to account for your client's symptoms. Work remained uninterrupted.

Further injury occurred in April 2022, lifting a heavy pole stuck under a car.
Symptoms have intensified, there was some weakness developing in the arm.

In May 2022 MRI of the cervical spine disclosed multilevel spondylotic changes, a non-cystic hyperintensity in the spinal cord between C3 and C5 with cord thinning compatible with myelomalacia.
There was also neurosurgical recommendation for a two-stage operation, fusion at the C4-5 level and multilevel bilateral foraminotomies between C3 and T1.

SURGERY:
In July 2022: C4-5 anterior cervical discectomy and integrated cage fusion.
In September 2022: Bilateral foraminotomies between C3 and T1.
Post-operative Radiology: On 27.7.2022 CT scan of the cervical spine acknowledged the fusion operation, finding no evidence of complications. On 6.9.2022 X-ray of the cervical spine acknowledged the C4-5 fusion with interbody cage device.

Outcome: Neck Symptoms**:** *"I still have slight neck pain. I feel I still have some restricted motions, a tightness in my neck"*.

Discussion: Patient sustained three subsequent cervical spine injuries, the initial insult 11 years prior to diagnosis of myelomalacia. The initial vertical compression of the spine likely having set in motion a disc degenerative condition, eventually the subsequent disc prominence resulting in pressure on the cervical spinal cord.

The diagnosis was post-traumatic myelomalacic myelopathy, non-cystic hyperintensity in the spinal cord between C3 and C5, cord thinning, compatible with myelomalacia.
Fusion was performed at C4-5 level, followed by foraminotomies but without central canal decompression. The fusion was performed at a level different from the level of spinal angulation, possibly causing future concerns if the myelomalacia fails to settle.

WPI: I assessed the worker on the basis of the Guides to the Evaluation of Permanent Impairment by the American Medical Association (5th Edition).

DRE Cervical Category IV: 27% WPI (including ADL).

Radiculopathy residual following surgery: 3% WPI.

Second Operation: 2% WPI.

Four-level additional surgery (foraminotomies): 4% WPI.

Surgical scars anteriorly and posteriorly in neck: 1% WPI (TEMSKI).

Based on the Combined Values Chart he has 34% WPI.

Conclusion: An interesting case of many years of left shoulder symptoms eventually related to cervical spine pathology. Questions remain regarding the exact site of pathology leading to the myelomalacia and
It is indeed one of the great challenges of diagnosis of this serious medical condition being the effect of repeated minor or a major injury. A serious

complication, this spinal cord degeneration is premature in an active age, it is progressive, is ischemic, softening partially or across the spinal cord. The peripheral signs are paralleling the roots, easy clinically to locate and further diagnose with Magnetic Resonance Imaging. It develops in spondylitic spine, in traumatic spine or in a spondylitic spine aggravated by trauma.

"**Lamb to the Slaughter**". Draft Application to Resolve a Dispute, an instructive example.

This 39-year-old Slaughterman commenced employment at Abattoirs in 1996 working initially as a labourer on the mutton floor and then as a floor boy which involved picking up bins around the floor and sweeping and cleaning which he did for about six months. He worked on the mutton floor for some 8 years and one of his tasks was to grab the carcass with his left hand, pull the carcass down and pull the skin with his right hand and then swap it over and do the other side using his right hand and punching down with his left hand. They were processing over 2000 a sheep a day and during this time he developed pain and stiffness in his wrists, fingers, both arms, shoulders, and his neck as well as his back. On the mutton line he was also required to pull the shoulders and during this, he developed aches and pain. On the mutton floor he was required to put the second leg up on sky hooks which required him to stand on his toes. It was heavy repetitive work requiring him to lift weights above his head. He subsequently moved to the beef floor cutting off heads which weighed approximately 20 kgs and carrying it to the head/skinning rail and throwing the head down the shute. He also worked on the pig floor for three years cutting the vertebrae in the neck while pulling with his right arm. Each pig's head weighed 10 kgs. He would behead approximately 1000 pigs per day which was quite heavy work.
In 2005 he washed the dressed pigs after they had been slaughtered which involved using a high-pressure hose on the inside and outside of the carcass as well as shaving the pigs and putting pigs onto overhead conveyors. They processed 500 to 700 pigs each day. He wore a Kevlar glove which was cut resistant but not cut proof. While doing so he developed pain and discomfort in his left hand. Additional duties included cutting the pigs into four quarters and he then did load out work for …, one of Abattoir's companies and then returned to work at Houston's where he would break down the pigs into four quarters.

He noticed after loading out at Houston's that he had increasing pain in his back and neck with paraesthesia in his hands as well as pain in his knees and ankles. In the course of the above employment, he had several injuries suffering several minor cuts and lacerations that required sutures. He sustained a laceration to his left thumb which required suturing and throughout his employment from 1996 to 2008 he developed carpal tunnel syndrome which did not settle with anti-inflammatories or physiotherapy. He had recurrent swelling of his fingers from punching down activities and he required physiotherapy for pain in his ankles which started after wearing gumboots on a wet concrete floor and he also developed pain in his knees while standing on cold concrete floors.

In late 2003/early 2004 on or about 20 January when working for Spackman Enterprises he was carrying a pig on his shoulder and slipped on a step jarring the middle of his back. He had review at the Young Medical Centre and at that time also had pain in his neck, knees, hands, wrists, elbows, and ankles. He subsequently had a bone scan which showed bruising to his vertebra in the thoracic region and subsequently had a period doing light duties for two months. He had recurrent pain, however, in his lower back and interscapular pain in the thoracic region, particularly when working the load out when he was required to lump 100 kg carcasses with an average of around 80 kg. He had pain on the process line where he had to bend, stoop, and push the heavy weight of beasts as they progressed along the line. As he wore gum boots, he did not have solid traction on the floor and had to push harder with his shoulders and lower back to keep the carcasses moving.

He noted significant pain in his neck with headaches having been struck in the neck several times with lamb and pig on automatic lines and at times, the apron around his neck pulled down on his neck and back. He had increasing pain in his shoulders made more severe by the heavy lifting of pig carcasses.

He did sustain tendon injury to the fingers of his left hand on 1 September 2004 when cutting the heads off steers and sustained a laceration between the MCP joint region of his index and middle fingers of the left hand and had to have three tendons repaired surgically in Wagga. He was off work for several weeks and had physiotherapy for several months. He returned to work doing office duties and gradually returned to full duties. He was then employed by R W R Management Services and made a claim through their insurer, CGU. Over the years he developed some post-traumatic stress disorder and anxiety and had ongoing problems with his back. He subsequently had a CT scan and a Nuclear

bone scan through a local doctor and was having difficulties doing his duties as a Slaughterman.

In January or February 2007, he had a fall from a horse and fractured his left wrist and had internal fixation and screws to stabilise the fracture and at the same time had left carpal decompression. He was off work for several months and then returned to light duties but noticed increasing pain in his wrists and particularly increasing pain in his neck, back, knees, ankles as well as residual pain in his fingers. He subsequently had review by a clinical psychologist because of depressive disorder. The pain in his back, neck, hands, and knees became too severe and on 15 February 2008 he resigned from Meat Processors.

As a result of his work injuries, he continued to suffer from interscapular pain in the thoracic spine and pain in his lower back with bilateral sciatic radiation as well as some neck pain. He had moderate pain in both ankles aggravated by walking and pain in both knees more marked on the left and pain in his wrists with paraesthesia in the fingers with pain at the base of the thumb in the left hand. There was residual aching in the joints and stiffness of his index and middle fingers of the left hand and very mild stiffness of his left wrist.

He continued to experience clicking and swelling in his ankles and has difficulty with prolonged standing or walking and had swelling of his left knee with some instability and ongoing bilateral knee pain. He had pain in his back with stiffness and difficulty attending the gym or fishing. He had regular massage and physiotherapy for his neck and shoulder pain and saw a pain specialist.
He had difficulty doing household chores, particularly taking the laundry out of the washing machine, and hanging washing on the line, vacuuming, sweeping and mopping and had difficulty mowing the lawn for his grandmother. He had increased pain in his back and knee and had difficulty putting on his shoes and socks and had persisting pain and paraesthesia in his hands.

He also believes he has suffered a loss of hearing due to working for Burrangong Meat Processors and although they were issued with ear plugs in 1998, he reported tinnitus and some loss of hearing over the years. Since his last review, the claimant has had additional surgery and has had bilateral carpal tunnel decompression. He reports residual paraesthesia in the thumb, index, and middle finger of the right hand.

In his latest statement dated 9 July 2019, the claimant notes he has persisting neck pain with pain radiating down both arms more marked on the right with

paraesthesia in the thumb, index and middle fingers and low back pain with sciatica, initially down the left leg and now down the right leg and he has residual pain in his left hip and left knee and has aggravated his right and left wrist, resulting in carpal tunnel decompression. He has had pain in the right hip which has required a cortisone injection and has had retro patellar pain in his right knee with recurrent subluxation of the patella as well as retro patellar pain in the left knee. He had MRIs of the cervical and lumbar spine in May 2019 which showed no gross disc protrusions but there was trochanteric bursitis of his lateral right hip which was confirmed on ultrasound, and he reports ongoing recurrent subluxation of his left shoulder.

He had further physiotherapy at Mercy Care Centre and now does his own home-based exercises, with the benefit of physiotherapy having plateaued. He has been using knee guards with holes cut out for the patellae to control swelling and to support his knees when required. He did have a cortisone injection to the right hip for the trochanteric bursitis which occurred while working in the abattoir and because of falls at work from October 2013 until 26 February 2016. The falls in the abattoirs were while working in the boning room and slaughter falls for both lamb and beef and have aggravated his neck and lower back as well as having recurrent dislocation of his right patella and problems with both wrists as a result of a bad fall in the boning room in January 2016, when he had finished the day and he went to grab two chopping boards, he slipped on fat on the floor, falling into a trolley and then falling heavily against a cryovac machine. He felt a pop in his neck and jarred his wrists and hips. He was concussed at the time but has no amnesia for the accident derails but is concerned that with his back pain, he had been limping as well as having pain in his neck, hips and wrists following the fall.

While pushing a meat carcass in January 2019 to the chillers in the abattoirs in Cootamundra, a scissor lift had been driven into a transformer, blowing it up. The carcass hit an air switch gate which came off the rails and the hook hit the claimant on the side of the head and the carcass fell onto him, injuring his left shoulder and his right patella popped out and he was knocked unconscious. He had a throbbing headache and had pain in his right hip and was sent home for bed rest and was picked up from the abattoirs complaining of knee, neck, shoulder and right hip pain and his girlfriend took him to Cootamundra District Hospital for assessment. He then returned to work after a couple of days. He was subsequently pulling skin off necks of lambs but felt he was unable to do it because of his injuries. This is hard work. They were slaughtering about 3,600 lambs per day and the Dorper lambs require more than one person to pull the

skin off as they are very tough. On this day, he had pulled the skins off by himself and he also had to cut the heads off as the automated head cutter had broken down.

While doing this work for four days he had pain in his wrists, hips, knees and back and shoulders and was unable to keep going and went to Wagga Wagga Base Hospital and attended Medcirc Clinic in Young and MRIs were arranged for his neck, lumbar spine and brain. He required analgesic medication but was unable to tolerate Panadeine Forte due to abdominal cramps and took anti-inflammatories as tolerated. He also had sciatic pain in the right buttock and ongoing bilateral knee pain and had paraesthesia in his right foot with weakness and recurrent paraesthesia in both hands. He went to see an optometrist in Young for irritation to his right eye during the course of his work duties, particularly with bone fragments, and protective eye wear was subsequently provided at work. His eye injuries occurred around 2014 and 2015.

WORK HISTORY: He worked at ……..at ……..from 1996 to 2008 for twelve years and was an A Grade Slaughterman and did loading out and worked for ……..as a butcher and meat cutter for four years.

SOCIAL HISTORY/ADL'S: He is living in a rental flat with a flat mate. He does not have to do gardens or lawns but still has difficulty with cleaning and heavy laundry and requires assistance from his flat mate to do household chores. He reports difficulty putting on his shoes and socks and doing his toenails and reports difficulty with prolonged standing to do meal preparation, cooking, washing up and bed making. He is not driving at present but when he is driving, he has difficulty with prolonged driving, and he is unable to play sport.

GENERAL HEALTH INCLUDING SUBSEQUENT OR PREVIOUS ACCIDENTS:
His general health has been satisfactory. He does have some episodes of dizzy spells. He reports no cortisone injection for his neck, back, elbows or wrists and apart from his left wrist fracture and internal fixation where he had carpal tunnel decompression, he reports no major surgical interventions.

CURRENT TREATMENT: He takes Panadol and anti-inflammatories, and he sees his local doctor regularly and will see the specialist as referred. It is proposed from the nerve conduction studies, that he had neurolysis of the ulnar nerve at the left elbow or lateral epicondylar release for tennis elbow which he has

developed during his abattoir duties. As noted above, he has had bilateral carpal tunnel decompression performed and had a cortisone injection to his right hp.

PRESENT SYMPTOMS: On review on 20 November 2019, he reports persisting occipito-frontal headaches with chronic pain in his neck and back with residual stiffness in his left shoulder with recurrent subluxation and he has difficulty with sustained elevation of his arms due to shoulder pain. He still has pain in the lateral aspect of his left elbow in the lateral epicondylar area and pain in his left wrist with intermittent paraesthesia in the fingers of his hand as well as paraesthesia in his right hand.

He reports pain in his lower back with sciatica pain now more marked on the right and he has a sitting and standing tolerance of up to one hour provided he can move about and a walking tolerance of half an hour and a driving tolerance greater than one hour. Although he does not own a car a present, he borrowed a vehicle from a friend to come to the appointment today. He still has difficulty with recreations such as fishing, and he is unable to play table tennis. He reports recurrent subluxation of his right patella and retro patellar pain in his left knee with difficulty kneeling and squatting and residual pain in his ankles.

EXAMINATION: On re-examination on 20 November 2019, he was 185 cm tall and weighed 97 kg. The range of motion of his cervical spine on forward flexion was satisfactory but there was pain on neck extension which was decreased by one third and lateral rotation decreased by one quarter bilaterally and lateral flexion decreased by one third. There was tenderness of the mid and upper cervical facet joints and both trapezius muscles. There was no gross neurological deficit of either upper limb or gross wasting. The Tinel's sign over the median and ulnar nerves of both wrists was equivocal. The Tinel's sign at the ulnar nerve at the right elbow appeared positive without subluxation of the nerve. His thenar power, grip strength and intrinsic power were grade 5 out of 5 and his carpal tunnel wounds had healed well. There was old scarring from the external fixateur following his previous wrist fracture. There was tenderness of the lateral epicondyles of both elbows, more marked on the left with positive provocation test more marked on the left.

There was restricted motion of his left shoulder with active abduction 140 degrees with forward flexion 160 degrees, extension 40 degrees, adduction 40 degrees, internal rotation 70 degrees and external rotation 80 degrees. There was subluxation of the left shoulder with a positive apprehension test. Shoulder

girdle power was grade 4 plus out of 5 on the left and grade 5 out of 5 on the right.

He had a full range of motion of elbows and wrists, thumbs, and fingers bilaterally. He had some interscapular pain with tenderness of the parathoracic muscles with trunk rotation decreased by one quarter bilaterally.

In the lumbar segment there was tenderness at the L5 level in the midline and the adjacent lumbosacral facet joints with forward flexion decreased by one third with pain on back extension which was decreased by one half and lateral flexion was decreased by one quarter bilaterally. His straight leg raise was 60 degrees bilaterally and associated with sciatic pain more marked on the right today. There was no gross neurological deficit of either lower limb or gross wasting. There was tenderness of the trochanteric bursa of his right hip. The range of motion of the right hip was satisfactory but he had a limp on the right on attempted toe and heel walking associated with trochanteric pain.

There was a positive apprehension test for subluxation at his right knee and retro patellar crepitus in his left knee. Both knees were otherwise stable. His normal gait was slow and heel walking was associated with right knee pain and squat testing was associated with knee pain more marked on the right and there was audible retro patellar crepitus in the left knee. The range of motion of his ankles was full. There was no apparent stiffness of the subtalar joints.

FURTHER RADIOLOGICAL INVESTIGATIONS: His further investigations include a bone scan on 13 April 2004 of the thoracic spine which showed increased uptake of the T9 vertebral body consistent with bone bruising that the previous x-rays.

CT of the thoracic spine on 13 April 2004 confirmed a 20% decreased height of T5 and to a lesser extent the T6 vertebral bodies.

X-ray of the left shoulder on 21 November 2006 done for shoulder clicking after his fall showed no bone or joint abnormality. There is still clicking today with recurrent subluxation.

X-ray of the left wrist and both feet on 16 January 2007 showed a fracture dislocation involving the distal radius with a grossly comminuted intra-articular fracture with displacement. This was following a fall from a horse.
X-ray of the left foot on 16 January 2007 showed a comminuted intra-articular fracture of the distal aspect of the first proximal phalanx.

X-ray of the right foot on 16 January 2007 showed a comminuted fracture of the distal aspect of the 1st proximal phalanx with a step in the articular surface.

These injuries followed a fall from a horse.

Progress x-ray of the left wrist on 18 January 2008 showed the radial fractures had healed.

X-rays of both elbows on 30 November 2009 showed the elbow joints were preserved and there was no degenerative or erosive arthritic change.

CT of the cervical spine on 30 November 2009 showed the vertebral outlines appeared normal and there was no gross disc protrusion.

CT of the lumbosacral spine on 30 November 2009 showed no degenerative change or facet arthritis or pars defects. There was no disc herniation.

X-ray of the cervical and thoracic spine on 7 September 2016 showed mild spondylitic disc, facet and uncovertebral joint changes with no significant foraminal narrowing.

X-ray of the thoracic spine on 7 September 2016 showed slight scoliosis convex to the right and no acute bone or joint abnormality.

X-ray of the left wrist, forearm and elbow on 9 February 2017 showed the old radial fracture. The elbow joint was aligned and there was no apparent effusion.

MRI of the brain for ongoing headaches done on 7 February 2019 showed no acute infarct or haemorrhage and no mass effect and no extra-axial fluid collection. The MRI was normal.

Ultrasound of the right knee and x-ray on 9 May 2019 showed suprapatellar joint effusion and no focal bony abnormality and quadriceps and patella tendons appeared intact as did the collateral ligaments. There were no Baker's or meniscal cysts.

MRI of the cervical spine on 29 May 2019 showed no significant disc herniation or focal disc protrusion. There was no canal stenosis or nerve root impingement.

MRI of the lumbar spine on 29 May 2019 showed no disc herniations or focal disc protrusion, canal stenosis or nerve root impingement.

Ultrasound of the right hip on 12 June 2109 showed trochanteric bursitis.

Ultrasound of the right elbow on 7 August 2019 showed the common flexor and extensor origin tendons were intact as the triceps tendon. There was no joint effusion and no olecranon bursitis seen.
X-ray and ultrasound of the left shoulder on 10 September 2019 showed no bony abnormality. There was subacromial bursitis. There was no bunching or impingement on abduction.

SUMMARY OF INJURIES AND DIAGNOSES:
In summary this claimant has sustained multiple injuries in the course of his work duties as an abattoir worker from June 1996 up until 26 February 2016 which has led to the aggravation and deterioration of his neck, shoulder, both elbows, carpal tunnel syndrome of both wrists, thoracolumbar spine and trochanteric bursitis of the right hip and recurrent patella dislocation of his right knee and post-traumatic chondromalacia patella of his left knee with retro patellar crepitus.

He had a frank injury in October 2014 when he slipped on a piece of fat and injured both wrists and had pain in his neck and left knee.
He had a frank injury in October 2015 when his right foot was caught in a trough and he slipped over, falling on the floor injuring both wrists, neck, left knee, left hip and back.

He had a frank injury in November 2015 when he was working and fell on a floor injuring both wrists, neck, left knee, left hip and back. He had a frank injury in January 2016 when he was working and fell heavily against a cryovac machine and felt a pop in his neck and sustained injury to his wrists and hips and was heavily concussed. He had a further injury in 2016 when he was pushing carcasses into the chillers when the carcass turned on the air switch gate which came off the rail, hitting the claimant on the head with significant head injury with loss of consciousness, injuring his left shoulder and right knee.

The nature and conditions of his employment from 2013 to 26 February 2016 where he performed repetitive bending and lifting of heavy weights have materially aggravated the injuries to his neck, shoulders, left elbow, left wrist, right elbow, right wrist, upper and lower back, right hip and both knees and were

disease provisions (Compensation Act) arising out of or during the course of his employment as a boner/labourer. He has contracted degenerative changes of his neck, shoulders, left elbow, left wrist, upper back, lower back, right and left hips, right and left knees, being a disease of such a nature to be contracted by a gradual process, to which his employment as a boner/labourer was a substantially contributing factor.

For several years prior to 26 February 2016, he was employed in the meat industry and this type of employment has been a substantial contributing factor to the aggravation, acceleration and deterioration of his neck, shoulder, elbows and wrists, back, right hip and both knees.

On presentation today, his main impairments appear to be:

1. Recurrent occipito-frontal headaches.
2. Subluxation of the left shoulder with a positive apprehension test.
3. Lateral epicondylitis of both elbows more marked on the left.
4. Residual ulnar neuritis at the medial left elbow.
5. Recurrent carpal tunnel symptoms and paraesthesia in his hands more marked on the right without motor weakness.
6. Thoracolumbar back strain injuries with a history of wedging of T5 and T6 and bruising of T9 with residual lumbosacral facet arthralgia and lumbar stiffness with radicular complaint with sciatic pain more marked on the right.
7. Trochanteric bursitis of the right hip with a limp.
8. Bilateral knee injuries with patella subluxation on the right and retro patellar crepitus on the left;
9. Reliance on analgesia and anti-inflammatories.
10. Impaction of his injuries on his activities of daily living including household chores such as heavy lifting of groceries and laundry and heavy cleaning. He is unable to do yard work which is done by others, and he has difficulty putting on shoes and socks and doing his toenails.
11. Post-traumatic stress disorder and anxiety about employability in the future.

CAUSATION: The above conditions are causally related to the nature and conditions of his employment as an abattoir worker.

FITNESS FOR WORK: He is not fit to work in abattoirs or do labouring work at present or work as a boner. He has tried to do a meat inspection course online and has done several modules. In order to do meat inspection, he needs to

complete this course. Meat inspection is a sedentary job, and he has the knowledge of the meat industry which would be a good choice for him if he was able to complete the course and meet the Government requirements of being a certified meat inspector.

DOMESTIC ASSISTANCE: His flat late helps him with the domestic chores as well as doing the yard work.

FUTURE TREATMENT: He requires ongoing analgesia and anti-inflammatories at a cost of $50 a month. He prefers not to take Panadeine Forte as this causes cramps and constipation. Review by his general practitioner each three months will cost $80 a visit. Review by his orthopaedic surgeon would cost $250. He has been taking Lyrica for neuropathic pain and his orthopaedic surgeon felt the claimant had left median and ulnar nerve compressive neuropathies at the elbow and felt there was median and ulnar neuropraxia with a positive Tinel left cubital tunnel and signs of carpal tunnel on the left and would require operative intervention. Today, the symptoms were more marked on the right.

CONSISTENCY OF PRESENTATION: He was consistent in presentation.

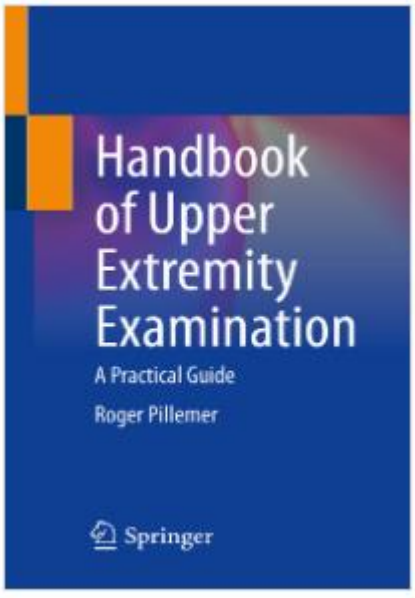
PROGNOSIS: His prognosis for returning to abattoir work is poor. Alternative job prospects have been discussed above such as meat inspection, depending on qualification, experience and as per Government regulation.

STABILISATION: His condition has stabilised in that there has been no significant change in the last three months and no significant improvement by more than 3% is expected in the next twelve months.

SPECIFIC QUESTIONS: In answer to your specific questions the claimant's condition and state of health before the alleged date of injuries or cessation of employment was satisfactory, apart from the compound fracture to his left wrist when he fell off the horse, requiring operative intervention and neurolysis of the median nerve carpal tunnel decompression (in 2007). He had not, to any extent, been complaining of injury or symptoms similar to those complained of after the alleged work injury, apart from the previous wrist fracture on the left. He was incapacited for work from that injury but after doing abattoir work for many years, he is now incapacitated for such work due to the injuries as described above.

He first consulted this practice on 24 November 2009 for medicolegal assessment and was reviewed on 20 November 2019. The history of work caused and/or work caused aggravation of any pre-existing condition, injuries and conditions diagnosed and treatment recommended or provided is in the above report as well as the investigations. He has been incapacitated for work since his last day of employ and had time off for his injuries, as noted, as required. His employment has been a substantial contributing factor to the injuries sustained and diagnosed as the nature and conditions of his work as an abattoir worker with numerous falls and various tasks performed have led to the above injuries. He will be restricted for employment in the abattoir working field for the reasonably foreseeable future. He is unfit to return to his pre-injury employment duties.

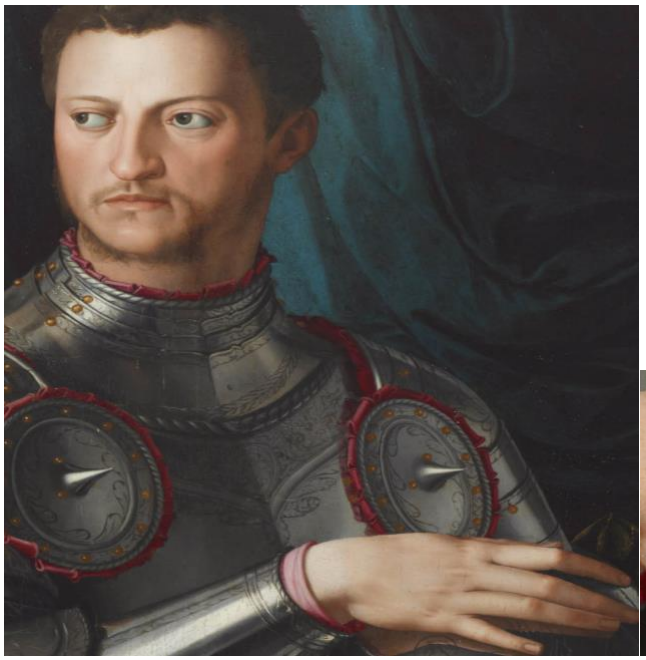
His condition is static and stable. His prognosis for returning to manual work remains guarded. He will have to do a more sedentary job such as meat inspection in the future. He does not have clerical training to do any office job. He does have whole person impairment. His future treatment reasonably required is in the above report. The benefit of physiotherapy has plateaued.



Recent publication: the objective is to emphasise the importance of physical examination. Hand, wrist, elbow and shoulders are discussed in dedicated thematic sections. The initial chapter describes the musculoskeletal anatomy, and functions of the joint; the second is the systematic examination in every case and the last chapter is examination of specific conditions relating to the joint .Colour images illustrates each test and physical sign. .

MEDICINE ON THE WALLS OF THE ART GALLERY: There is a longstanding historic connection between medicine and the creative arts, with many health personnel regarding their professional work as a creative endeavour, and a surprising number also devoting their leisure time to music, literary activities, or the visual arts. This association is the Medico-artistic phenomenon to which this physician dedicated the retirement time. VISITING ART GALLERIES, EACH OF US LOOKS AT HIS/HER INTEREST AND SPECIALTIES. As an orthopaedic surgeon, I am looking for hand deformities. Examples are presented from the Art Gallery of NSW, Sydney.(with permission):


Nicolas Largelliere :***Portrait of an officer.***




Cosimo Medici I, in armour : (1519-74) Duke of Florence, By Bronzino

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