

Bond University

Bond Law Review

Volume 35

Issue 1

2023

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‘Fully Diagnosed, Fully Stabilised and Fully Treated’: Succeeding in a Claim for a Disability Support Pension in Australia for Endometriosis and Chronic Pelvic Pain

KARENA VIGLIANTI-NORTHWAY *

Abstract

In 2019, Ms Natasha Thomson won an application for a disability support pension (DSP) under the Social Security Act 1991 (Cth)¹ before the Australian Administrative Appeals Tribunal (AAT).² Ms Thomson was taken to the AAT by the Department of Social Security³ when it appealed a decision of the AAT’s Social Services and Child Support Division. Ms Thomson is the only applicant with chronic pelvic pain and likely endometriosis that has succeeded in her claim for a DSP before the Tribunal since 2005. Endometriosis is an inflammatory condition characterised by endometrial-like tissue growing outside the uterus, which can result in pain and adhesions. It commonly grows on the pelvic organs and peritoneum but has been found in other parts of the body, such as the lungs, diaphragm, kidney and navel. There is no cure at present. Long-term management is required using medical and/or surgical treatment, both of which focus on alleviating symptoms.⁴ In this article, I consider the AAT’s determinations and set out what applicants, their legal representatives and their treating doctors can learn from the cases on applicants for a DSP with endometriosis and chronic pelvic pain.

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¹ *Social Security Act 1991* (Cth) (‘SSA’).

² The Administrative Appeals Tribunal is referred to as either the ‘AAT’ or the ‘Tribunal’ throughout this article. *Re Thomson; Secretary, Dept of Social Services and (Social Services Second Review)* [2019] AATA 1094 (‘*Thomson*’).

³ The Department of Social Security is referred to as the ‘Department’ in this article. References are also made to ‘Centrelink’ in this paper. For the purposes of this article, the two terms should be taken as interchangeable.

⁴ Clinical practice guidelines and consensus statements describe endometriosis as ‘common, enigmatic, relapsing and, for some women, debilitating’: see Rebecca O’Hara et al, ‘Should Endometriosis be Managed within a Chronic Disease Framework? An Analysis of National Policy Documents’ (2018) 42(6) *Australian Health Review* 627, 628.

I Introduction

Part II summarises why we need to care about ensuring that a system of appropriate disability support is provided to women with endometriosis and chronic pelvic pain. This includes a summary of the literature on the extent and impact of endometriosis on women who suffer from the disease, as well as a summary of the impacts of the disease on the Australian economy. Part II also sets out the extent to which the medical academy has identified the problems created by an unconscious gender bias in the dealings of health practitioners with their female pain patients, with the result that many women have their disease and the pain it causes dismissed or left untreated. This creates a range of problems, both for the patient themselves as well as for society that bears the burden of further health costs and lost productivity.

Part III sets out the key components of the legislative framework for obtaining a DSP in Australia. This Part highlights the complexity of the criteria an applicant needs to address to obtain a DSP. Part IV examines a number of cases that have come before the AAT of women with endometriosis and chronic pelvic pain, highlighting the lessons that women with endometriosis and experts can learn from the cases to ensure an applicant's enhanced chance of success of obtaining a DSP. Part V concludes that there are substantial hurdles that women with endometriosis and chronic pain must overcome to be successful in an application for a DSP. It concludes that the current process is complex and not likely to be one that a woman experiencing⁵ the severest effects of endometriosis could easily navigate without substantial support.

⁵ In this article I have used the term 'experience' rather than 'suffering'. This term has been adopted in the most recent literature as being the appropriate way to describe disability (including pain conditions) rather than the term 'suffering' (previously adopted by the medical model of disability). The medical model of disability has now been criticised on a number of bases, including for the negative connotations conjured by term 'suffering'. For a discussion on the various models of disability and their appropriateness see, eg, Mamo Retief and Rantoo Letšosa, 'Models of Disability: A Brief Overview' (2018) 74(1) *HTS Theologiese Studies/Theological Studies* 1; Steven R Smith, 'Social Justice and Disability: Competing Interpretations of the Medical and Social Models' in Kristjana Kristiansen, Simo Vehmas and Tom Shakespeare, *Arguing about Disability: Philosophical Perspectives* (2009, Routledge) 23. Note that the legislation itself and some of the judgments in this area do appear to adopt the medical model of disability in their continued use of the term 'suffering'. The description itself is not particularly relevant to the central discussion of this article. I note it here however for completeness.

II Background: Why Should We Care About Supporting Women with Endometriosis and Chronic Pelvic Pain?

A *The Medical Profession and Women in Pain: The Diagnosis and Treatment Gap Created by Unconscious Bias and the Creation of a Special Vulnerability*

To provide context to the extent of the problem and by way of background only, this Part sets out a summary of some of the findings on the impacts of chronic pelvic pain and endometriosis and the difficulties faced by women with endometriosis and chronic pelvic pain. There is an extensive literature about this reporting specific research from a range of relevant disciplines (including medicine and the social sciences).⁶ A small sample of this literature is referenced in this article providing expert evidence about the disease and its impacts, including how the medical profession views and responds to many women presenting with endometriosis and chronic pelvic pain. This article also attempts to build on research undertaken by Professor Terry Carney on the continued erosion of social support for persons with disabilities by the Commonwealth Government over time.⁷

Endometriosis is a disease that currently has no cure. It is characterised by tissue similar to the lining of the uterus growing in other parts of the body.⁸ It has a high incidence rate, affecting approximately 7-10% of Australian women of reproductive age, with an estimated 619,924 Australian women having endometriosis at some point in their life.⁹ The common symptoms of endometriosis include chronic pelvic pain, dysmenorrhea, deep dyspareunia, dysuria, dyschezia, fatigue, and infertility, all of which affect the physical, mental, sexual, and social well-being of women who experience the disease, as well as their productivity and long term financial position.¹⁰

⁶ Including relevant details of the various methodological approaches of the relevant disciplines to detail the problems faced by women with endometriosis.

⁷ See, eg, Terry Carney, 'Disability Support Pension: Towards Workforce Opportunities or Social Control' (1991) 14(2) *University of New South Wales Law Journal* 220, 230. For more recent comments by Professor Carney on the lack of disability support for cancer patients see Luke Henriques-Gomes, 'Disability Pension Rules Leave Thousands with Cancer on \$44 a Day', *The Guardian Australia Online*, 10 October 2021.

⁸ Ernst & Young, *The Cost of Endometriosis in Australia* (Web Report, 29 May 2019), <<https://endoactive.org.au/wp-content/uploads/29May2019-FINAL-The-Cost-of-Endometriosis-in-Australia-EY-EndoActive-Report.pdf>> ('Ernst & Young').

⁹ Ernst & Young (n 8) 6.

¹⁰ See O'Hara et al (n 4) 630, 631; Ernst & Young (n 8) 19–26 on these impacts. In summary, endometriosis can lead to a range of problems, including 'chronic pelvic pain, dysmenorrhea, deep dyspareunia, dysuria, dyschezia, fatigue, and infertility', affecting 'physical, mental, sexual, and social well-being': Krina Zondervan, Christian Becker and Stacey Missmer, 'Endometriosis' (2020) 382(13) *The New England Journal of Medicine* 1244, 1244; Rebecca O'Hara, *Endometriosis Management in Australia: Policy, Practice and Women's Experiences* (PhD Thesis, Monash University, 2019) Chapters 3, 6 and 7. Each of these sources contain lists of the many symptoms associated with endometriosis and the corresponding disadvantage

Research by experts also suggests that disadvantage is created for women with endometriosis and chronic pain because they are likely to have their valid health concerns dismissed by health professionals.¹¹ For example, the medical academy has extensively researched and documented (through a combination of both qualitative and quantitative research methods) the experience of women's interactions with the medical profession, including attempts by female patients to obtain proper diagnoses of their health problems and, in turn, appropriate treatment and management for their health condition.¹² These studies have included detailed examinations of women experiencing one of the most common symptoms of endometriosis, namely, chronic pelvic pain.¹³ The research contains many general studies on the operation of a gender bias by health professionals and supports the theory that these interactions most often work against women in their dealings with the health system.¹⁴ The studies are based not just on qualitative research,

these symptoms create. For a very good analysis of the effect of chronic disease on every aspect of a sufferer's life see Havi Carel, *Illness* (2013, Acumen Publishing).

¹¹ See, eg, Anke Samulowitz et al, 'Brave Men and Emotional Women: A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain' (2018) *Pain and Research Management* 1; Roger B Fillingim et al, 'Sex, Gender and Pain: A Review of Recent Clinical and Experimental Findings' (2009) 10(5) *Journal of Pain* 447; Joel D Greenspan et al, 'Studying Sex and Gender Differences in Pain and Analgesia: A Consensus Report' (2007) 132(1) *Pain* (Supplement 1) S26; Camran Nezhat, Farr Nezhat and Ceana Nezhat, 'Endometriosis: Ancient Disease, Ancient Treatments' (2012) 98(6) *Fertility and Sterility* 61; Kate Young, Jane Fisher and Maggie Kirkman, "'Do Mad People get Endo or Does Endo Make You Mad?': Clinicians' Discursive Constructions of Medicine and Women with Endometriosis' (2019) 29(3) *Feminism & Psychology* 337; Hafdis Skuladottir and Sigridur Halldorsdottir, 'Women in Chronic Pain: Sense of Control and Encounters with Health Professionals' (2008) 17(7) *Qualitative Health Research* 891; Anne Werner and Kristi Malterud, 'It is Hard Work Behaving as a Credible Patient: Encounters Between Women with Chronic Pain and their Doctors' (2003) 57(8) *Social Science and Medicine* 1409; Anne Werner, Lise Widding Isaksen and Kristi Malterud, "'I am not the Kind of Woman who Complains of Everything': Illness Stories on Self and Shame in Women with Chronic Pelvic Pain' (2004) 59(5) *Social Science and Medicine* 1035.

¹² See the very helpful summary of many of these studies in the Commonwealth's 'National Action Plan for Endometriosis', Commonwealth Department of Health (Web Page, July 2018), <<https://www.health.gov.au/sites/default/files/national-action-plan-for-endometriosis.pdf>>. (the 'NAP'). See also summaries of the evidence set out in O'Hara et al (n 4) 631, 632–633 and Ernst & Young (n 8) 37–38 and sources cited at (n 11).

¹³ Ibid.

¹⁴ For example, see the research and findings in the following peer reviewed publications: Stephen Colameco, Lorne A Becker and Michael Simpson, 'Sex Bias in the Assessment of Patient Complaints' (1983) 16(6) *The Journal of Family Practice* 1117; Dierdre English and Barbara Ehrenreich, *Complaints and Disorders: The Sexual Politics of Sickness* (1973, The Feminist Press); Cassandra Mackey and Deborah Diercks, 'Gender Bias in the Management of Patients Still Exists' (2018) 25(4) *Academic Emergency Medicine* 647; American Medical Association Council on Ethical and Judicial Affairs, 'Gender Disparities in Clinical Decision Making' (1991) 266(4) *Journal of the American Medical Association* 559; Karen Armitage, Lawrence Schneiderman and Robert Bass, 'Response of Physicians to Medical Complaints in Men and Women' (1979) 241(20) *Journal of the American Medical Association* 2186; Selina Redman et al, 'The Effects of Gender on Diagnosis of Psychological Disturbance' (1991) 14(5) *Journal of Behavioural Medicine* 527; Ann Oakley, 'Women, Health and Knowledge: Travels Through and Beyond Foreign Parts' (1993) 14(4) *Health Care for Women International* 327; Shari Munch, 'Gender-Biased Diagnosing of Women's Medical Complaints: Contributions of Feminist Thought 1970-1995' (2008) 40(1) *Women and Health* 101; Elizabeth Fee, 'Women's

primarily undertaken through surveys of both the women impacted and the medical professionals who treat them; they are also supported by quantitative research into the different health outcomes recorded by health systems for both men and women presenting with symptoms to their doctors and hospitals.¹⁵ For example, in one study it was found that women are less likely to be diagnosed with a heart attack when they present to emergency departments because the medical model of health and illness is still predominantly viewed (and taught at medical school) as being male.¹⁶ Since women presenting with heart attack have slightly different symptoms to men, doctors often don't pick up the warning signs of a heart attack in women.¹⁷ This research did not find that the medical practitioners treating these patients deliberately ignored the women presenting. Rather, the studies just discussed found that the practitioners simply did not pick up the symptomology in the first place. This was understood to be because gender bias had been created by the medical model the practitioners had been taught as the acceptable model of illness at medical school.¹⁸

The available evidence suggests that the medical model frequently attributes complaints about symptomology by women as being 'all in their heads' because the model itself has been primarily focused on male symptomology. Thus, anything outside the typical male illness presentation pattern, is not neatly classified and treated by a medical practitioner because that presentation does not appear in the research by the medical academy as taught to practitioners.¹⁹ Since women's

Nature and Scientific Objectivity' in Ruth Hubbard and Marian Lowe (eds), *Women's Nature: Rationalizations of Inequality* (Pergamon Press, 1983) 155; John Ayanian and Arnold Epstein, 'Differences in the Use of Procedures Between Women and Men Hospitalized for Coronary Heart Disease' (1991) 354(4) *The New England Journal of Medicine* 221.

¹⁵ These studies employ various quantitative approaches acceptable in the discipline of medicine and medical research. The individual papers detail the specific methodologies used by the researchers to substantiate their respective findings.

¹⁶ See, eg, Sabine Oertelt-Prigione and Vera Regitz-Zagrosek, *Sex and Gender Aspects in Clinical Medicine* (2012, Springer).

¹⁷ Ayanian and Epstein (n 14) 221, 223. See also the findings in relation to gender disparity and the treatment of pain in emergency departments in Esther Chen et al, 'Gender Disparity in Analgesic Treatment of Emergency Department Patients with Acute Abdominal Pain' (2008) 15(5) *Academic Emergency Medicine* 414; Megan Miller et al, 'The Influence of Patient Sex, Provider Sex and Sexist Attitudes on Pain Treatment Decisions' (2014) 15(5) *The Journal of Pain* 551.

¹⁸ Ayanian and Epstein (n 14); Oertelt-Prigione and Regitz-Zagrosek (n 16). See also Elinor Cleghorn, *Unwell Women: A Journey Through Medicine and Myth in a Man-Made World* (2021, Weidenfeld & Nicholson).

¹⁹ On this point see Cleghorn (n 18); Samulowitz et al (n 11); Fee (n 14); Anita Houlcroft, 'Gender Bias in Research: How Does it Affect Evidence Based Medicine?' (2007) 100(1) *Journal of the Royal Society of Medicine* 1; James Katz, Rachel Seaman and Shari Diamond, 'Exposing Gender Bias in Medical Taxonomy: Toward Embracing a Gender Difference without Disenfranchising Women' (2008) 18(3) *Women's Health Issues* 151; Melanie Racine et al, 'A Systematic Literature Review of 10 Years of Research on Sex/Gender and Experimental Pain Perception — Part 1: Are There Really Differences between Women and Men?' (2012) 153(3) *PAIN* 602; Gunilla Risberg, Eva Johansson and Katarina Hamberg, 'A

illnesses do not neatly fit into the dominant model of illness, women's health complaints can get dismissed all too easily by individual practitioners educated in that system as being 'psychosomatic'.²⁰ One of the most identified problems in the relevant research to date is that health practitioners often ignore or dismiss the health concerns (often over long periods of time) of women complaining of pain, particularly women presenting with chronic pelvic pain, including pain caused by endometriosis.²¹ In summary, the available scholarly research suggests that women complaining of chronic pain (like that caused by endometriosis) are more likely than not to have their health concerns dismissed or ignored by their treating doctors, because the medical model is not based on women's symptomology.²² The research suggests that these women, who are presenting to health professionals with real, physiological pain, are therefore most likely to have their health complaints treated by their doctors as being psychosomatic in nature.²³

The good news is that the medical academy has been particularly busy over the last decade in attempting to consign these theories of acceptable illness patterns (based on the male model of illness), and the poorer medical care they lead to, to the dust bin of history.²⁴ Unfortunately however, the expert literature to date suggests that many of these attitudes still endure in medical practice, particularly since they are often the result of an unconscious bias by a woman's treating doctors, rather than any deliberate course of conduct on the health practitioner's part to ignore their patient's real health concerns.²⁵ The problem with the dismissal of women's pain is that, according to the

Theoretical Model for Analysing Gender Bias in Medicine' (2009) 8(28) *International Journal for Equity in Health* 28.

²⁰ Samulowitz et al (n 11); Fee (n 14); Houldcroft (n 19); Katz, Seaman and Diamond (n 19); Racine et al (n 19); Risberg, Johansson and Hamberg (n 19).

²¹ As noted above, these studies employ both qualitative and quantitative methodologies to reach these conclusions. The impact of the bias results in significant delays in diagnosis of endometriosis. See the helpful summary of women's experience in this respect documented in the NAP (n 12) 2, 4 and sources cited there. See also the reports in O'Hara et al (n 4) 632 and Ernst & Young (n 8) 21. For medical literature on the medical profession's dismissal of complaints by women in pain see the sources cited above at n 11 and n 14. For a detailed history of the multiple failures of the medical profession to diagnose and treat women with endometriosis specifically see Nezhat, Nezhat and Nezhat (n 11) 61–62; Katerina Bryant, *Hysteria: A Memoir of Illness, Strength and Women's Stories Throughout History* (2020, New South Publishing); and Young, Fisher and Kirkman (n 11) 337–356, 338, 344, 346–347. For a discussion of the limitations of the framework of modern, Western medicine and the medical clinic more generally see the foundational work on the topic by Foucault in Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (1973, Vintage Books).

²² See sources above at n 11 and n 14.

²³ Ibid. This idea of the 'hysterical female' is an idea with a long lineage in medical practice based on a conception of women that has been tainted by gender bias. See, eg, Nezhat, Nezhat and Nezhat (n 11); Bryant (n 21); Young, Fisher and Kirkman (n 11) 337, 342, 347, 439, 350, 351–352; NAP (n 12) 2, 4; O'Hara et al (n 4) 632 and Ernst & Young (n 8) 21.

²⁴ See, eg, Nezhat, Nezhat and Nezhat (n 11); Bryant (n 21); Young, Fisher and Kirkman (n 11).

²⁵ See the specific medical literature cited in Ernst & Young (n 8) 37–38. See also the literature on the operation of unconscious gender bias cited above at n 11 and n 14.

experts, it can lead to delays in the diagnosis of endometriosis.²⁶ In turn, the research finds that these delays lead to poorer treatment for the disease and its negative impacts, leading to a range of poorer long-term health and economic outcomes for sufferers of the condition.²⁷

B Endometriosis: The Cost to Patients and to Australia

In 2018, the Australian Government announced its National Action Plan (NAP) for Endometriosis.²⁸ As part of the NAP, the Government summarised the literature to date on the multifarious, disadvantageous impacts of endometriosis on the lives of women who live with the disease, as well as the cost of the disease to Australia more generally.²⁹ As noted above, apart from debilitating pain and negative impacts on women's functioning in all aspects of life, there are documented, significant direct health costs for sufferers of the disease. For example, it is estimated that direct healthcare costs to a woman with endometriosis amount to approximately \$6,529 for each year she suffers from the disease, resulting in a direct health cost of \$129,993 to her in her lifetime (based on conservative estimates).³⁰ It is also estimated that people with chronic diseases like endometriosis are 60% more likely to not be able to participate in the labour force, are less likely to be employed full time and are more likely to be unemployed than those without chronic disease.³¹ The Commonwealth Government estimates that approximately 700,000 women in Australia are currently affected by the disease.³² The loss of income incurred by a woman with endometriosis represents a significant cost to those women and their families. Research indicates the condition could be more common than breast cancer and diabetes for women aged 15 to 49, costing Australian

²⁶ See the summary of these multifarious problems set out in the NAP (n 12) 2, 4 and the sources cited there. See also the reports in O'Hara et al (n 4) 632 and Ernst & Young (n 8) 21.

²⁷ See NAP (n 12) 2, 4; O'Hara (n 4) 631 and Ernst & Young (n 8) 17–23, 26–27. See also the discussion in Part B of this article for a description of the range of negative impacts of the disease, including the negative economic impacts of the disease.

²⁸ NAP (n 12).

²⁹ Ibid. See also Kelechi Noaham et al, 'Impact of Endometriosis on Quality of Life and Work Productivity: A Multi-Center Study Across Ten Countries' (2011) 96(2) *Fertility and Sterility* 366; Steven Simoens et al, 'The Burden Endometriosis: Costs and Quality of Life of Women with Endometriosis and Treated in Referral Centres' (2012) 27(5) *Human Reproduction* 1292; Maryam Moradi et al, 'Impact of Endometriosis on Women's Lives: a Qualitative Study' (2014) 14(1) *BMC Women's Health* 123; Deborah Bush, Susan Evans and Thierry Vancaillie, 'The \$6 Billion Woman and the \$600 Million Girl: The Pelvic Pain Report' (Web Report, 2011) <<https://www.pelvicpain.org.au/pelvic-pain-report/?v=ef10366317f4>>; Mike Armour et al, 'The Cost of Illness and Economic Burden of Endometriosis and Chronic Pelvic Pain in Australia: A National Online Survey' (2019) 14(10) *PLoS One* 1; Ahmed Soliman et al, 'The Direct and Indirect Costs Associated with Endometriosis: A Systematic Literature Review' (2016) 31(4) *Human Reproduction* 712.

³⁰ Ernst & Young (n 8) 17.

³¹ Ibid 19, citing statistics from the Australian Institute of Health and Welfare, *Chronic Disease and Participation in Work* (Report, 11 February 2009).

³² Reported on the then Health Minister's (Greg Hunt) webpage on 11 January 2021 (URL no longer available).

society \$7.7 billion each year, with two-thirds of that figure attributed to lost productivity and the rest attributed to direct healthcare costs.³³

In summary, apart from chronic pain, the economic burden imposed on women with endometriosis is significant, due to both the medical costs associated with managing the disease and the loss of work and productivity the disease causes. That financial loss is experienced by both women with the disease and the Australian economy. Although the impacts of the disease are pervasive, literature to date in the legal academy has mainly focused on how women's reproductive conditions affect rights to equality of treatment in areas like employment and fertility.³⁴ As far as I know, no specific consideration has been given to the intersection of the legal system on the other many aspects of disadvantage the disease creates for women's lives more generally. This article is a small step in attempting to commence bridging some of that gap. The reason women with endometriosis and chronic pelvic pain may need to apply for a DSP is because of the disruption it causes to their lives, but the analysis in this article suggests that applications by women for a DSP who have the condition are generally not successful before the Tribunal. At present then there is a gap between what the expert research suggests the impacts of the disease are and what the Tribunal might order for women experiencing some of the worst symptoms of endometriosis and chronic pelvic pain.

In the next Part, I analyse the complex legislative framework that confronts a woman applying for a DSP based on endometriosis and chronic pelvic pain.

III Legislative Framework for a DSP in Australia

In this Part, I set out the relevant legislative framework that an applicant with endometriosis or chronic pelvic pain must be aware of when making an application for a DSP in Australia, focusing on the key provisions that have proven to be most important (and most problematic) in cases that have gone before the AAT.

An applicant qualifies for a DSP under the SSA if:

- (1) the person has a physical, intellectual or psychiatric impairment³⁵ and the person's impairment is 20 points or more under the 'Impairment

³³ See NAP (n 12) 2; Ernst & Young (n 8) 7 (estimating the cost to be approximately \$7.4 billion annually).

³⁴ See, eg, Beth Goldblatt and Linda Steele, 'Bloody Unfair: Inequality Related to Menstruation - Considering the Role of Discrimination Law' (2019) 41(3) *Sydney Law Review* 293; Thomas Hvala, 'In Vital Need of Reform: Providing Certainty for Working Women Undergoing IVF Treatment' (2018) 41(3) *University of New South Wales Law Journal* 901; Catharine Carroll and Gemma McGrath, 'Intellectual Disability and the Right to Family Life: Equality Under the Law' (2014) 122 *Precedent* 10, 12.

³⁵ SSA (n 1) s 94(1).

Tables'. The Impairment Tables issued under the SSA³⁶ provide a list of matters to be taken into account in assessing a claimant's level of impairment. The Impairment Tables contain guidance on how the Tables are to be applied.³⁷ Section 6 of the Tables sets out how the functional capacity of an applicant for a DSP is to be assessed. Of relevance in assessing the functional capacity of an applicant are ss 6(3), (4), (5), (6) and (7) of the Impairment Tables. In summary, this includes that the applicant's condition must be permanent, meaning that the condition is 'fully diagnosed', 'fully treated' and 'fully stabilised'. The Impairment Table for endometriosis,³⁸ and the details of the type of impairments that are relevant for assessment under that Table for a claim based on the impacts of endometriosis or chronic pelvic pain, are set out in Appendix 1 to this article. The issue of how the Impairment Tables are applied is discussed further in Part III below;

(2) the person has a continuing inability to work.³⁹ A person has a 'continuing inability to work' because of an impairment if the Secretary⁴⁰ is satisfied that the impairment is, of itself, sufficient to prevent the person from doing any work independently of a program of support within the next two years and either the impairment is of itself sufficient to prevent the person from undertaking a training activity during the next two years, or such an activity is unlikely (because of the impairment) to enable the person to do any work independently of a program of support within the next two years.⁴¹

'Work' is defined as work:

³⁶ Ibid ss 23, 26(1), 94(1). The Impairment Tables were made pursuant to a determination by the Minister dated 6 December 2011 (see *Social Security (Tables for the Assessment of Work-Related Impairment for Disability Support Pension) Determination 2011* (Cth)). See also *Re Bell and the Department of Social Security* (1994) 19 AAR 406 on the approach to impairment assessment generally. Impairment is defined in s 3 of the Impairment Tables to mean 'a loss of functional capacity affecting a person's ability to work which results from the person's condition'.

³⁷ Section 4 of the Impairment Tables set out the rules for interpreting the Tables. Parts 2 and 3 of the Tables set out the rules for applying them for the purposes of s 26(3) of the SSA (n 1). Ibid s 26 provides that '(1) The Minister may, by legislative instrument, determine tables relating to the assessment of work-related impairment for disability support pension'. SSA (n 1) s 26(3) provides that 'The Minister may, in an instrument under subsection (1), determine rules that are to be complied with in applying the tables referred to in subsection (1) and the provisions referred to in subsection (2)'.

³⁸ Impairment Table 10 (digestive and reproductive conditions). The 2011 Guidance provided from the Department on the Impairment Tables is that endometriosis should be treated as falling under 'Table 10' which is to be 'used where the person has a permanent condition resulting in functional impairment related to digestive or reproductive system functions': see *Social Security Guide*, Version 1.253, Section 3.6.3.07, outlining examples of Table use for permanent conditions. Table 10 provides that 'reproductive system conditions may include gynaecological diseases (eg severe and intractable endometriosis, ovarian cancer) and conditions of the male reproductive system (eg testicular cancer)'. In *Thomson* (n 2) the Department argued that the relevant Table for endometriosis is Table 10: *Thomson* (n 2) [84].

³⁹ Or if the Secretary of the Department of Social Security (Cth) is satisfied that the person is participating in the supported wage system administered by the Commonwealth: SSA (n 1) s 94(5).

⁴⁰ The Secretary of the Department of Social Security (Cth).

⁴¹ SSA (n 1) s 94(2)(a).

(a) that is for at least 15 hours per week on wages that are at or above the relevant minimum wage; and

(b) that exists in Australia, even if not within the person's locally accessible labour market.⁴²

A Assessing Impairment Levels (Functional Capacity)

As noted above, the first requirement that an applicant for a DSP must meet is that she has a 'physical, intellectual or psychiatric impairment'⁴³ that meets the threshold requirement of 20 points or more ('severe impairment') under the applicable Impairment Table (Table 10).⁴⁴ Table 10 guides an appropriately qualified medical practitioner to use an assessment rating scale as to the level of functional impairment caused to the applicant by a health condition under the Table to assess the level of impairment of the applicant.⁴⁵ The Department offers very generalised advice to applicants via their website on the evidence they may require an applicant to provide in support of their application.⁴⁶ The manner in which the Department then assesses the claim is also rather complex.⁴⁷ Although this is beyond the focus of the present article, the process of assessment includes assessment by the Department of both non-medical and medical considerations.⁴⁸ The general medical rules that apply reflect the legislative conditions discussed in this Part.⁴⁹ The Department then has the ability to investigate any of the matters claimed by the applicant. This may include officers of the Department speaking to the applicant's medical practitioners,⁵⁰ as well as requiring the applicant to attend a Disability Medical Assessment by a medical practitioner appointed by the Department.⁵¹ An applicant might also be required by the Department

⁴² Ibid. Other key requirements under the legislation include that the applicant must have already turned 16 and must: '(1) be an Australian resident; (2) have 10 years qualifying Australian residence or have a qualifying residence exemption for a disability support pension; or (3) have been born outside Australia, but becomes an Australian resident while a dependent child of an Australian resident': SSA (n 1) s 94(1)(e). See also SSA (n 1) s 7 (definition of 'Australian resident', 'qualifying Australian residence' and 'qualifying residence exemption').

⁴³ SSA (n 1) s 94(1).

⁴⁴ See n 38.

⁴⁵ See Appendix 1 for the full content of Table 10.

⁴⁶ Including an extensive list of documents, such as all medical records, complete financial records, details of living arrangements and personal relationships, details of education, details of any compensation paid to the applicant as well as details of any other benefits being received by the applicant as well as verification of identity documents.

⁴⁷ For full details see the information provided on the Department's website (Web Page, 8 April 2023) <<https://www.servicesaustralia.gov.au/how-we-assess-your-claim-for-disability-support-pension?context=22276>>.

⁴⁸ Ibid.

⁴⁹ See n 47 for full details of these rules.

⁵⁰ Ibid.

⁵¹ Further details about the Disability Medical Assessment can be found online at (Web Page, 8 April 2023) <<https://www.servicesaustralia.gov.au/disability-medical-assessment-for-disability-support-pension?context=22276>>. The report created by the medical expert under this process helps the Department decide if the applicant meets the requirements for a DSP.

to attend a Job Capacity Assessment to assess her ability to work.⁵² Finally, after the case has been conducted and any relevant assessments are conducted, the applicant is notified of the Department's decision as to whether she has been granted a DSP or not.⁵³ This decision is then subject to specific avenues of potential review.⁵⁴

In summary, this process is not 'user friendly' and it is difficult to understand. Although issues concerning the navigation of the Department's processes are not the focus of the present article, I note them in passing as they provide some insight into the system that applicants have to plot a course through before they even reach the possibility of review of a Departmental decision by the Tribunal. This system is the subject of my current research for further publication in a future paper.

1 *Condition Must Be Permanent*

Section 6(3) provides that an impairment rating can only be assigned to an impairment if: (a) the person's condition causing that impairment is 'permanent'. 'Permanent' is defined as meaning that 'the impairment that results from that condition is more likely than not, in light of available evidence, to persist for more than 2 years'. As I discuss in Part III, proof of this requirement has been one of the greatest challenges facing sufferers of endometriosis who have applied for a DSP.⁵⁵

Section 6(4) provides that, for the purposes of 6(3)(a), a condition is permanent if:

- (a) the condition has been fully diagnosed by an appropriately qualified medical practitioner; and
- (b) the condition has been fully treated; and
- (c) the condition has been fully stabilised; and
- (d) the condition is more likely than not, in light of available evidence, to persist for more than 2 years.

I discuss in detail below what proof of each of these elements requires.

Section 6(5)(b) of the Impairment Tables also importantly provides that the Tables are 'function based rather than diagnosis based', 'describe functional activities, abilities, symptoms and limitations' and 'are designed to assign ratings to determine the level of functional impact of impairment and not to assess conditions'. I discuss the specific importance of the need to assess the functional impairment caused by the applicant's health condition in Part III below.

⁵² Ibid (for details of this process).

⁵³ Ibid.

⁵⁴ Ibid. These include internal reviews by an Authorised Review Officer within the Department (Centrelink) and then, finally, review by the AAT.

⁵⁵ As to how this requirement has been treated by the AAT, see Part III below.

(a) Fully Diagnosed and Fully Treated

‘Fully diagnosed and fully treated’ is defined by s 4(5) of the Impairment Tables. The section provides that, in determining whether a condition has been fully diagnosed by an appropriately qualified medical practitioner and whether it has been fully treated, the following matters are to be considered:

- (a) whether there is corroborating evidence of the condition; and
- (b) what treatment or rehabilitation has occurred in relation to the condition; and
- (c) whether treatment is continuing or is planned in the next 2 years.

(b) Fully Stabilised

Section 4(6) of the Impairment Tables provides that a ‘condition is fully stabilised’ if:

- (a) either the person has undertaken reasonable treatment for the condition and any further reasonable treatment is unlikely to result in significant functional improvement to a level enabling the person to undertake work in the next 2 years; or
- (b) the person has not undertaken reasonable treatment for the condition and:
 - (i) significant functional improvement to a level enabling the person to undertake work in the next 2 years is not expected to result, even if the person undertakes reasonable treatment; or
 - (ii) there is a medical or other compelling reason for the person not to undertake reasonable treatment.

‘Reasonable treatment’ is then defined by s 4(7) as meaning treatment that:

- (a) is available at a location reasonably accessible to the person; and
- (b) is at a reasonable cost; and
- (c) can reliably be expected to result in a substantial improvement in functional capacity; and
- (d) is regularly undertaken or performed; and
- (e) has a high success rate; and
- (f) carries a low risk to the person.

Section 11(4) of the Impairment Tables relevantly provides:

When assessing impairments caused by conditions that have stabilized as episodic or fluctuating a rating must be assigned, which reflects the overall functional impact of those impairments, taking into account the severity, duration and frequency of the episodes or fluctuations as appropriate.

B *Assessing Pain Conditions under the Impairment Tables*

One further matter of relevance for applicants (with endometriosis or chronic pelvic pain) in interpreting the Impairment Tables is the guidance that is offered by the Tables on how the functional impact of pain caused by a condition is to be assessed. This is because one of the key impacts of endometriosis is pain.⁵⁶ Section 9 of the Tables provides:

- (9) Where there is no Table dealing specifically with pain and when assessing pain, the following must be considered:
- (a) acute pain is a symptom which may result in short term loss of functional capacity in more than one area of the body; and
 - (b) chronic pain is a condition⁵⁷ and, where it has been diagnosed, any resulting impairment should be assessed using the Table relevant to the area of function affected; and
 - (c) whether the condition causing pain has been fully diagnosed, fully treated and fully stabilised for the purposes of subsections 6(5) and (6).

Table 10 also relevantly provides that an assessment of impairment can take into account 'symptoms associated with reproductive system conditions' that can 'include, but are not limited to, pain, fatigue, menorrhagia or dysmenorrhea'.⁵⁸

This complex regulatory framework, containing criteria within criteria, is what an applicant needs to address in her evidence to be successful in her claim for a DSP. It may be little wonder then that only one applicant has been successful before the AAT in being able to provide sufficient evidence to satisfy each of the statutory criteria. In the next Part, I examine the cases that have gone on appeal to the Tribunal and identify the guidance they provide to applicants making a claim for a DSP.

⁵⁶ O'Hara et al (n 4) 628; Nicholas Leyland et al, 'Endometriosis Diagnosis and Management' (2010) 2(3) *Journal of Endometriosis* 107. See also NAP (n 12) 2, 4; Ernst & Young (n 8) 26–27; O'Hara (n 10) *Endometriosis Management in Australia: Policy, Practice and Women's Experiences* Chapters 3, 6 and 7.

⁵⁷ Recognising that chronic pain is a condition that is separate from endometriosis had an impact on the success of Ms Thomson's claim, as she was able to establish that her chronic pain condition (rather than any endometriosis) had been fully diagnosed, had fully stabilised and was fully treated. The Tribunal noted that the regulatory framework and prior decisions support the finding that chronic pain is to be treated as a separate condition: *Thomson* (n 2) [53], [55]–[59]. I discuss further the significance of this argument in Ms Thomson's case in Part III below.

⁵⁸ Menorrhagia is the medical term for menstrual periods with abnormally heavy or prolonged bleeding. Dysmenorrhea is the medical term for pain with menstruation or menstrual cramps.

IV Succeeding in an Application for a Disability Support Pension with Endometriosis or Chronic Pelvic Pain: The Tribunal's View

In this Part, I consider the cases decided by the AAT involving applicants with endometriosis and chronic pain. An applicant appears in a hearing before the Tribunal only after following a series of levels of reviews after having had their application for a DSP rejected by the Department. The first step is for the applicant to seek a formal review of the Department's decision from an Authorised Review Officer within the Department.⁵⁹ From there, an applicant can lodge a further appeal with the Tribunal.⁶⁰ This appeal can then go through two levels of appeal.⁶¹

In this Part, through examining the cases that have gone before the AAT, I identify the lessons provided by those cases in terms of what an applicant needs to do to succeed in a claim for a DSP.⁶² I examine the cases because the lessons from the cases that have been determined by the Tribunal apply to any application to the Department, as well as before any appeals panel (whether an internal review or to the AAT). In summary, only one of the five cases for a DSP that have gone on appeal to the AAT has been successful, namely the claim brought by Ms Thomson. In the appeals that failed, the claimants were unsuccessful because they did not satisfy the AAT that the applicant's condition (endometriosis or chronic pain) was permanent insofar as the condition had not been fully diagnosed or fully treated. The failures⁶³ here have included (i) failure to provide sufficient corroborating evidence of the condition being claimed;⁶⁴ (ii) failure to provide sufficient evidence of

⁵⁹ See *Social Security (Administration) Act 1999, (Cth)* ('SSA Act'), Part 4A. Undertaking this first review is a necessary step. An appeal cannot be made to the AAT unless an applicant has first sought an internal review by an Authorised Review Officer within Centrelink.

⁶⁰ SSA Act (n 59) Part 4A.

⁶¹ Ibid.

⁶² These decisions include *Bugno and Secretary, Department of Employment and Workplace Relations* [2005] AATA 788 ('*Bugno*'); *Polat and Secretary, Department of Social Services* [2014] AATA 609 ('*Polat*'); *Re Ghazzawie and Secretary, Dept of Social Services* [2017] AATA 1051 ('*Ghazzawie*'); *Thomson* (n 2) and *QM/JL and Secretary, Department of Social Services (Social Services Second Review)* [2020] AATA 1841 ('*QM/JL*'). In *Martin and Secretary, Department of Social Services (Social Services Second Review)* [2016] AATA 176 the applicant did make an application that included a claim for endometriosis. The case however was primarily run on the basis of the applicant's brain injury. For this reason, I have excluded this decision from my analysis. In *KSWB and Secretary, Department of Social Services (Social Services Second Review)* [2018] AATA 2153 ('*KSWB*') the applicant's claim was based primarily on other pelvic and urogenital conditions (not endometriosis or chronic pain). It was not made clear from the evidence whether these conditions were related to the applicant's endometriosis and a claim was not made on the basis of her endometriosis. For this reason, I have likewise excluded this decision from my analysis.

⁶³ By 'failure' I mean that there is a lack of evidence from which the Tribunal is satisfied that the applicant has established the relevant statutory criteria. As discussed throughout this Part, the applicant must meet each one of the statutory criteria in order to meet the requirements under the legislation to obtain a DSP.

⁶⁴ *Bugno* (n 62) [25], [33]; *Polat* (n 62) [19]; *Ghazzawie* (n 62) [35]–[36]; *QM/JL* (n 62) [30].

what treatment or rehabilitation had occurred in relation to the condition;⁶⁵ and (iii) failure to provide sufficient evidence of whether treatment was continuing or what treatment was planned in the next 2 years.⁶⁶ This included a lack of evidence of whether the applicant had pursued conventional medical treatment.⁶⁷ Claimants have also been unsuccessful because they have not established that the condition had fully stabilised; that is, there was insufficient evidence that further reasonable treatment was not likely to result in significant functional improvement to a level enabling the applicant to undertake work in the next 2 years.⁶⁸

For the remainder of this Part, I consider these evidential failures in detail and summarise what an applicant must do in order to overcome them.

A Failure to Establish the Condition is Permanent

As noted above, establishing that a condition is permanent requires proof that the condition has been fully diagnosed and that the condition has been fully treated. I now discuss the difficulties that have confronted applicants in establishing each of these elements.

1 Failure to Establish the Condition has been 'Fully Diagnosed'

There are a number of cases that have gone before the AAT in which women who applied for a DSP on the basis of impairment caused by their endometriosis sought to establish that their condition had been fully diagnosed.⁶⁹ In this Part, I examine how applicants can address this criterion using the guidance the cases provide.

(a) Providing a Detailed and Complete Medical History

The first lesson from these cases is that applicants need to ensure that they have obtained (or can show evidence of their attempts to obtain) access to their full medical history, even where that medical history of relevant symptomology may go back over many decades. For example, if a diagnosis of endometriosis has been provided by a medical expert, who the Tribunal recognises as being sufficiently accredited (such as a gynaecologist), doubt can still be thrown on the diagnosis by the Department's own medical experts. If the applicant's entire medical

⁶⁵ *Bugno* (n 62) [21].

⁶⁶ *Ibid.*

⁶⁷ *Ibid* [21], [50]; *Ghazzawie* (n 62) [35]–[36].

⁶⁸ *Bugno* (n 62) [45].

⁶⁹ Including *Bugno* (n 62); *Polat* (n 62); *Ghawazzie* (n 62) and *QMJL* (n 62). Thomson applied on the basis that her condition was 'chronic pelvic pain', not endometriosis. I discuss the ramifications of this below at Part III A 1 (a).

history is not available for interrogation, she may face a significant disadvantage in establishing that her condition has been ‘fully diagnosed’. In other words, applicants must be prepared to comprehensively rebut any uncertainty in the diagnosis of their condition that might be raised by the Department’s evidence. The clearest example of this difficulty to date was in the AAT’s decision in *Bugno*.

Ms Bugno’s story is one that many long-term sufferers of endometriosis will immediately recognise. Her evidence was that she suffered from chronic fatigue, migraines, depression, low immunity, food allergies, hormone imbalances, pain in various parts of her body, as well as weakness in her legs and arthritis.⁷⁰ She also had difficulty thinking and her communication skills were deteriorating.⁷¹ The applicant was 48 years old by the time her claim came before the AAT in 2005. She had suffered from these (or similar) symptoms for many decades (since 1984)⁷² and had stopped working in 2002 as a result of her worsening symptoms.⁷³

The AAT noted that Ms Bugno had tendered extracts of her Medicare records since 1984, and from those records it was established that she had consulted a number of medical practitioners and had undertaken a variety of medical tests and procedures since that time.⁷⁴ As discussed, this is a common narrative for endometriosis sufferers who are used to reporting symptoms to doctors, only to have their health problems ignored or dismissed.⁷⁵ Two X-ray reports from 1992 and 1993 did indicate endometriosis, and a subsequent laparoscopy had confirmed that diagnosis in 1995.⁷⁶ Notwithstanding this body of evidence relating to the diagnosis of endometriosis, the Tribunal still found in Ms Bugno’s case that there was ‘only scant evidence concerning the results of any such consultations, tests or procedures’.⁷⁷ This appears to be because the Tribunal was concerned that the most recent tests and results had not been put into evidence by Ms Bugno.⁷⁸

⁷⁰ *Bugno* (n 62) [19].

⁷¹ *Ibid.*

⁷² *Ibid.*

⁷³ *Ibid.*

⁷⁴ *Ibid* [21].

⁷⁵ See Part I of this article for further discussion and analysis of this point.

⁷⁶ *Bugno* (n 62) [21]. A laparoscopy is a medical procedure used to examine the interior of the abdominal or pelvic cavities for the diagnosis or treatment (or both) of a number of different diseases and conditions, including endometriosis. The procedure examines the interior of the abdominal or pelvic cavity using a slender tube (laparoscope) inserted through a small incision. Samples of tissues can be taken and sent off for testing for a definitive diagnosis of endometriosis. The procedure remains the ‘gold standard’ for diagnosis of the disease: see *Thomson* (n 2) [30].

⁷⁷ *Bugno* (n 62) [21].

⁷⁸ *Ibid* [21]–[24]. This finding was made even though it appears that Ms Bugno only undertook the further tests at the direction of Centrelink. It might reasonably be inferred that the Department would have had access to those records by the time the matter came before the

Ultimately, it appears that, since Ms Bugno did not have complete copies of reports by all the doctors she had seen, including her most recent reports, the Tribunal determined that there was insufficient evidence to support her claim that she had been fully diagnosed with endometriosis. Instead, the Tribunal Member concluded that there was an absence of evidence of a 'comprehensive history of clinical investigation, examination and assessment of her impairment' by qualified medical practitioners.⁷⁹ One of the doctors Ms Bugno had consulted at Centrelink's direction had also offered this rather unhelpful opinion: 'Complex set of symptomatology, both physical and mental. Exact diagnosis uncertain. Pathological testing not rewarding'.⁸⁰ The statement that Ms Bugno's diagnosis was uncertain appeared to override any certainty that had come from Ms Bugno's earlier medical records, including her laparoscopy and its diagnosis of endometriosis.⁸¹

In *Ghazzawie*, a claim for a DSP for endometriosis also failed on the basis that the condition of the applicant had not been fully diagnosed. The Tribunal found that the medical evidence had not reached a stage to enable it to draw any final conclusion about the permanency of the applicant's condition because the medical specialist had said that the applicant was awaiting a laparoscopy for a 'definitive diagnosis' of endometriosis.⁸² On that basis, the Member found that her condition was not 'permanent'.⁸³ This leads us to consider whether or not having a laparoscopy together with a resulting definitive diagnosis of endometriosis from that procedure is a pre-condition to establishing that a woman has endometriosis for the purpose of establishing that she has been 'fully diagnosed'.

(b) Undertaking a Laparoscopy as a Pre-Condition to Diagnosis

The decisions on whether an applicant needs to have undergone a laparoscopy to diagnose endometriosis (to establish that she has been fully diagnosed) are not altogether clear. Much depends on the applicant's specific circumstances and the resulting medical opinion. It should be remembered that this consideration has arisen under two distinct elements of the legislation; that is, whether the applicant's condition is 'permanent' and whether the applicant's condition has been

AAT, or at the very least, could have easily produced those records to the AAT if asked to do so by the Member.

⁷⁹ *Bugno* (n 62) [21]–[24].

⁸⁰ *Ibid* [25].

⁸¹ Despite that laparoscopy is still regarded by the Department and the Tribunal as the 'gold standard' for diagnosis of endometriosis: see n 76.

⁸² *Ghazzawie* (n 62) [35]–[36].

⁸³ *Ibid* [36]. It is not entirely clear from the reasons provided by the Member whether the Tribunal found that there was insufficient evidence to determine that the functional impact of the condition on Ms Ghazzawie was permanent, or whether the diagnosis of endometriosis was not permanent. The reasons suggest the latter interpretation is correct.

‘fully treated’. Consideration of these two elements has necessarily involved some overlap of this factual question as a separate consideration by the Tribunal in the decided cases and has accordingly led to a lot of overlap and repetition in the AAT’s analysis of these two requirements. In this Part, I consider the necessity of undertaking a laparoscopy as part of proof that the applicant’s condition is ‘permanent’. I discuss in the next section how this consideration is taken into account as part of determining whether the applicant’s condition has been ‘fully treated’. It will be seen that, although the statutory elements are distinct, the factual analysis for each element is often very similar, if not almost identical. The consideration of these concepts results in what appears to be (unavoidable) repetition of the facts relevant to two elements that must be proven under the legislation.

In *Bugno* the applicant had been diagnosed via laparoscopy as having endometriosis, even though later expert evidence supposedly created some doubt about this for the Tribunal.⁸⁴ The diagnosis provided by that laparoscopy, argued by the Department to be the standard for diagnosis of endometriosis according to both the Department and the Tribunal,⁸⁵ was not sufficient in Ms Bugno’s case to establish that she had been fully diagnosed. As discussed above, this appears to have had more to do with the weight the Tribunal placed on the Department’s expert’s opinion and the lack of recent medical records from accepted medical practitioners more than anything else.⁸⁶ In *Ghazzawie*, the Tribunal insisted that the applicant’s failure to have a laparoscopy meant that no definitive diagnosis of endometriosis had yet been made.

In *Thomson*, the applicant had not undertaken a recent laparoscopy, and an earlier laparoscopy had not been able to conclude that Ms Thomson had endometriosis.⁸⁷ To address this difficulty, Ms Thomson claimed that the relevant condition, her ‘chronic pain’, was fully diagnosed. Following the approach in *Bugno and Ghazzawie*, the Department argued that Ms Thomson’s condition was not ‘fully diagnosed’ because she needed to undertake a further laparoscopy to determine whether she had endometriosis or another gynaecological disorder.⁸⁸ The AAT rejected this submission, basing its finding on the fact that the condition the applicant relied on in support of her DSP application was not ‘endometriosis’ or some other ‘gynaecological illness’. Rather, Ms Thomson had made clear that the condition she

⁸⁴ See the discussion on this above at Part III A 1 (a).

⁸⁵ *Thomson* (n 2) [30]. See also n 76.

⁸⁶ The supposed lack of recent medical evidence from an accredited medical practitioner in Ms Bugno’s case is discussed below in detail at Part III A 2 (c).

⁸⁷ *Thomson* (n 2) [16].

⁸⁸ *Ibid.* The Tribunal noted that this procedure was not likely to produce any further conclusion on diagnoses than a laparoscopy that Ms Thomson had recently undertaken.

relied on was 'chronic pain'.⁸⁹ As such, the question for the Tribunal was whether her 'chronic pain' condition was fully diagnosed, not whether some potential condition that could be the underlying cause of her chronic pain (endometriosis) had been fully diagnosed.⁹⁰ Focusing on that question, the AAT found that the applicant had provided evidence from leading medical experts on the treatment of her chronic pain over many years.⁹¹ Importantly, the Department's own medical expert had opined that Ms Thomson had chronic pain 'as a symptom and a condition'.⁹² The available inference for the Tribunal was that chronic pelvic pain is not just a symptom of what has traditionally been considered as a gynaecological disorder (endometriosis); rather, it is recognised by medical experts as a condition in and of itself. This approach paved the way for the Tribunal to find in Ms Thomson's favour on the evidence she presented to them of the diagnosis of her chronic pain condition and its functional impact on her.

The lesson for future applicants from these cases appears to be that a claim may have a greater chance of success if it is made on the basis that the relevant condition is 'chronic pain' rather than 'endometriosis', particularly where the diagnosis of endometriosis is uncertain. Applicants and their advisers, however, will need to be confident that they can demonstrate that the applicant's medical history shows a long list of the impacts of chronic pain in the applicant's particular case before approaching a claim on that basis. This needs to be considered carefully in light of warnings the Tribunal issued in *Thomson* about the limits of its findings being restricted to Ms Thomson's particular circumstances. I discuss those warnings further below.⁹³

(c) Dealing with Conflicting or Unclear Expert Opinion

Another lesson for applicants is that they need to be able to rebut any medical opinion relied upon by the Department that lacks clarity. The decisions establish that applicants need to be extremely careful when they have been required to submit themselves to examination by medical practitioners who have little knowledge of (or do not attempt to find out) the relevant details of an applicant's long-standing and complex symptomology. An expert who expresses a pre-emptive opinion (particularly an expert for the Department) might damage an applicant's case significantly. If an expert for the Department does express such an opinion, the applicant should consider having her own accredited (and trusted) expert clearly address the problems with the Department's expert's opinion.

⁸⁹ *Thomson* (n 2) [16].

⁹⁰ *Ibid.*

⁹¹ *Ibid* [17]–[19].

⁹² *Ibid* [19].

⁹³ At Part III Part B 2 (a).

This issue formed part of the problem for Ms Bugno. As noted above, Ms Bugno had consulted a doctor as directed by the Department. This expert complicated Ms Bugno's claim because he provided both a more recent medical opinion of her diagnosis (or lack thereof) and also because his medical opinion provided an evidential basis for the Tribunal to find that Ms Bugno's condition had 'not stabilised'.⁹⁴ Even though the medical expert for the Department made clear that he could not actually provide a diagnosis unless he had access to Ms Bugno's clinical history or until further tests were undertaken by her, he still professed a concluded opinion that Ms Bugno's medical condition had 'not stabilised'.⁹⁵

The lesson for applicants is that it is likely to be useful if a recent medical opinion is obtained by the applicant from her own treating doctors that clearly addresses any uncertain or incongruous medical opinion placed before the Tribunal.

(d) Do Not Express a View on the Limits of Current Medical Treatments and Using Acceptable Specialists

The cases suggest that there is very little to be gained by an applicant expressing any opinion about her view of the failures of conventional medicine to assist her in the management of her condition. Such views are not relevant to the assessment process and may not be viewed favourably by the Tribunal.

In *Bugno*, the applicant gave evidence that she had given up on attending doctors to help her with her condition, instead attending an acupuncturist for treatment of her symptoms.⁹⁶ As discussed in Part I, Ms Bugno is hardly alone in having had the experience of being a woman who has been let down by conventional medicine in the diagnosis or management of her condition.⁹⁷ Whilst this seems a reasonable position for Ms Bugno to take, the Tribunal Member appeared to take a dim view of her evidence that she had given up on conventional doctors whilst, at the same time, submitting herself to

⁹⁴ *Bugno* (n 62) [31]. The impacts of this finding are discussed below in Part III B 3.

⁹⁵ *Bugno* (n 62) [31]. The expert also said that she would recover in 6 months (even though she had been struggling with her health for decades): *ibid*. The issue of whether the applicant's condition has 'fully stabilised' is discussed further below in Part III B 3. Ultimately, the state of the expert evidence led the Tribunal to conclude that it was not possible (on the available evidence) 'to determine with any certainty the precise nature of her impairment': *Bugno* (n 62) [33].

⁹⁶ Ms Bugno told the Tribunal: 'I have tried medical doctors over the decades but there [sic] tests never show anything, and now I refuse to go! Having blood tests can trigger off migraines [sic] and my veins split when dye is injected into them. Also, the dye given in X-rays has given me psoriasis of the skull. Besides my original problems, courtesy of the medical profession, I now have many more!': *Bugno* (n 62) [20].

⁹⁷ On these failures see sources cited in *Ernst & Young* (n 8) and *NAP* (n 12). See also sources cited in *O'Hara et al* (n 4) 632. For a more detailed history of the multiple failures of medicine to diagnose and treat women with endometriosis see *Nezhat, Nezhat and Nezhat* (n 11); *Bryant* (n 21) and *Young, Fisher and Kirkman* (n 11) 351.

seeing more doctors as directed by Centrelink.⁹⁸ No allowance appeared to be given for the fact that Ms Bugno probably felt that she had very little choice in the matter.⁹⁹ Whether this ultimately affected her credibility is not entirely clear. There appears to be at least a fair inference that it did not help her.

There is also a real question about whether an applicant benefits from producing any evidence from a practitioner that is not a conventional medical practitioner. Ms Bugno's most recent treating health practitioner was an acupuncturist and not regarded by the Tribunal as an appropriately qualified person to express any opinion of weight. Certainly, the evidence of the alternative therapists who were treating Ms Bugno by the time she made her DSP application appeared to undo any positive effect the evidence from her earlier medical records, and from an accredited specialist, may have otherwise had.¹⁰⁰

In contrast with the position Ms Bugno found herself in, Ms Thomson was able to produce expert opinion from an acceptable and very senior medical practitioner in the treatment of chronic pelvic pain conditions (such as endometriosis) at one of the most respected medical establishments in the State of Victoria.¹⁰¹ It should be noted that none of these differences is a criticism of Ms Bugno.¹⁰² The differences do appear to reflect that Ms Thomson may have had the benefit of better access to medical and legal resources that Ms Bugno may not have had.¹⁰³ Ms Thomson had expert opinion and a detailed medical history that was very difficult to contradict. This shows what type of challenges an applicant is likely to face in proving her case if she diverges from using conventional, accredited medical specialists to diagnose and treat her condition. It also demonstrates that the same specialists should then be used to provide detailed evidence on her behalf if required.

2 Failure to Establish that the Condition has been 'Fully Treated'

Proving that an applicant's condition has been 'fully treated' is another key hurdle that applicants must overcome. The problems that applicants may face that can be identified from the cases on this criterion include

⁹⁸ *Bugno* (n 62) [25].

⁹⁹ See n 51 on directions from the Department on medical assessment.

¹⁰⁰ *Bugno* (n 62) [28]–[29].

¹⁰¹ *Thomson* (n 2) [17]–[19]. Ms Thomson was receiving treatment from Dr Peter Maher, Director, Clinical Professor, University of Melbourne, Department of Endosurgery, Mercy Hospital for Women. At the time of providing the report for Ms Thomson, Dr Maher was then a clinical professor at the Department of Obstetrics and Gynaecology at the University of Melbourne. Ms Thomson thus received her treatments for her chronic pain at some of the best hospitals in Victoria, including the Alfred Hospital and then the Mercy Hospital.

¹⁰² *Thomson* (n 2) [17]–[19].

¹⁰³ Ms Thomson managed to obtain some advice from Legal Aid: Luke Henriques-Gomes, 'Department Fought to Deny Disability Pension to Woman in Chronic Pain' *The Guardian Australia Online*, 23 July 2019.

(a) proving that laparoscopy is not a 'reasonable treatment' of her condition; (b) proving that hormone therapy is not a 'reasonable treatment' of her condition; (c) proving that she has followed recommended treatments from health practitioners the Tribunal recognises as appropriately qualified to express a relevant opinion; (d) proving that the cost of a recommended treatment is not reasonable in her specific circumstances.

For reasons I discuss in this Part, a medical expert engaged by the applicant might consider focusing their evidence on whether the applicant has undertaken available reasonable treatments by (a) setting out any reasonable treatments the applicant has undertaken to date and what impact (if any) they have had on the applicant's functional capacity; (b) setting out whether any further treatments are available and why those treatments are not reasonable in her case, including whether the treatments: (i) have a poor success rate for the condition; and (ii) are likely to result in a substantial improvement in the applicant's functional capacity in any event.

An expert report must also deal with any suggested 'reasonable' treatments proffered by a qualified medical expert for the Department, including addressing why any recommended treatment by any other expert is (a) not related to the applicant's health condition; and/or (b) does not have a high success rate for the condition; and/or (c) is not likely to result in a substantial improvement in the applicant's functional capacity.

For the remainder of this Part, I consider what guidance has been provided by the AAT on how to address the question of whether an applicant's endometriosis or chronic pelvic pain has been 'fully treated'. This includes consideration of the following issues raised by the cases (a) whether laparoscopy is a reasonable treatment; (b) whether hormone therapy is a reasonable treatment; (c) whether pursuing unconventional treatments is acceptable; and (d) whether the cost of, or ease of access to, suggested treatments makes the suggested treatment reasonable in the applicant's particular circumstances.

(a) Is a Laparoscopy a 'Reasonable Treatment'?

As noted above, there is a degree of factual overlap between this consideration and the consideration of whether the applicant's condition is 'permanent'. I ask the reader to bear with me as I undertake the analysis in this section in relation to the specific issue of whether a laparoscopy is a 'reasonable treatment' as part of addressing whether the applicant's condition has been 'fully treated'. Repetition in this part, as in the cases themselves is, unfortunately, unavoidable, as each issue is a separate and distinct element that requires specific consideration in its own particular right. Since it has been treated in this way by the

Tribunal, it is necessary for me to analyse this requirement separately as well.

The cases are not clear on whether undertaking a laparoscopy is a 'reasonable treatment' for either endometriosis or chronic pelvic pain. Much depends on the particular facts in the applicant's case, including the condition being claimed.

In *Thomson*, there was a divergence of medical opinion on whether all reasonable treatments had been undertaken by Ms Thomson, with Ms Thomson arguing that her condition was 'chronic pain' and the Department arguing her condition was 'endometriosis'.¹⁰⁴ In the Department's submission, Ms Thomson had not undertaken all reasonable treatment for endometriosis.¹⁰⁵ In particular, the medical expert for the Department expressed the view that the underlying condition causing Ms Thomson's pain (endometriosis) had not yet received the best available treatment of laparoscopy.¹⁰⁶ In his view, reasonable treatment would involve investigating, diagnosing and then treating the underlying condition that was causing Ms Thomson's pain.¹⁰⁷ This would have to be achieved by a further laparoscopy and potential hormone treatment.¹⁰⁸ The Tribunal rejected the Department's submission that the relevant condition to be treated was 'endometriosis' for the following reasons. First, endometriosis had not been diagnosed to date, a fact that had been accepted by the Department's own expert.¹⁰⁹ Second, Ms Thomson was not relying on endometriosis as the relevant condition causing her impairment for the purpose of her DSP application; she was relying on her 'chronic pain' condition.¹¹⁰ The Tribunal found that the question was whether the condition as claimed (chronic pain) was fully treated, not whether an undiagnosed condition (endometriosis) had been fully treated. This is a technical argument. Nonetheless, it is one that appears to be available based on the way in which a claim is made. That is, that the applicant suffers from impairment caused by chronic pain as its own condition, not chronic pain as a symptom of some other, underlying condition (endometriosis) potentially causing the applicant's pain. Third, the laparoscopy (recommended by the Department's medical expert) was not a procedure related to 'treatment' based on the evidence presented by the Department itself. Since, according to their own expert, laparoscopy

¹⁰⁴ As already noted above, Ms Thomson had applied for a DSP based on her 'chronic pain', not 'endometriosis'. The Department argued this was not correct: *Thomson* (n 2) [28].

¹⁰⁵ *Ibid.*

¹⁰⁶ See above n 76.

¹⁰⁷ *Thomson* (n 2) [29]–[36].

¹⁰⁸ Including pathology of tissue samples taken during that procedure: *ibid.* In *Thomson*, it does appear that the medical expert for the Department did not make clear whether excision of diseased tissue was part of the recommended treatment for endometriosis or just part of diagnosis of the condition. The use of hormone therapy is discussed below at Part III A 2 (b).

¹⁰⁹ *Thomson* (n 2) [30].

¹¹⁰ *Ibid* [30], [33].

was primarily diagnostic in nature, the Department had not characterised it as a ‘treatment’.¹¹¹ Further, the medical evidence adduced by both parties did not suggest that a laparoscopy would result in any improvement in Ms Thomson’s condition. It could therefore not be argued to be a further reasonable ‘treatment’ that Ms Thomson had to undergo.¹¹² The medical evidence established that she had undergone a recent laparoscopy that had provided only temporary relief from her pain condition.¹¹³ On that basis, the Tribunal was able to find that it was not reasonable for her to undertake yet a further laparoscopy with little expected benefit to her in reducing her pain.

Following earlier authority on the issue of whether laparoscopy is a reasonable treatment,¹¹⁴ the AAT noted that, simply because a medical expert expresses the view that some different treatment may still be available to the applicant at some time in the future (which treatment could still offer her some hope of relief from her pain) this does not of itself preclude a finding that the applicant has already undertaken all reasonable treatment and that her condition has been ‘fully treated’.¹¹⁵ The Tribunal pointed out that a condition can still be considered to be ‘fully treated’ even though future treatments are contemplated and, hopefully, available to the applicant.¹¹⁶ As Gyles J put the point in *Harris*:¹¹⁷

Where the condition is chronic pain the prospect of further procedures or further treatment cannot be an automatic bar to receipt of a DSP. Unless it is assumed that the community of health professionals had given up on a patient suffering chronic pain, the prospect of further diagnostic procedures or further treatment intended to ameliorate pain will, at any particular time, be inevitable.¹¹⁸

¹¹¹ This was because the Department had already submitted that Ms Thomson needed to undergo the procedure for diagnosing endometriosis to establish her condition had been ‘fully diagnosed’. See Part III A 1 (b) above for this argument as part of the diagnosis of Ms Thomson’s condition.

¹¹² *Thomson* (n 2) [35].

¹¹³ *Ibid.*

¹¹⁴ In *Harris v Secretary, Department of Employment and Workplace Relations* [2007] FCA 404 (‘*Harris FCA*’); approved). Approved on appeal in *Secretary, Department of Employment and Workplace Relations v Harris* [2007] FCAFC 130 (‘*Harris FFC*’).

¹¹⁵ *Thomson* (n 2) [43].

¹¹⁶ *Ibid.*

¹¹⁷ *Harris FCA* (n 114) [17] (Gyles J). Approved on appeal in *Harris FFC* (n 114) [37] (French, Tamberlin and Rares JJ).

¹¹⁸ Cited in *Thomson* (n 2) [50] with approval. The Tribunal also made clear that it was not correct to say that an applicant has not been optimally treated absent a definitive diagnosis of the underlying condition causing a pain condition: *Thomson* (n 2) [46]–[49]. This is consistent with what the Tribunal had said in *Bugno* (n 62), even if the actual result in *Bugno* seems at odds with the approach in *Thomson* on this point. In *Bugno*, the Tribunal said: ‘Diagnosis is part of the medical process of investigation of impairment which includes the development of treatment options and a prognosis. As the preamble to the Impairment Tables makes clear, the Tables are not based on diagnosis, but go to the impairment of function. For that reason, what is required for the purpose of subparagraph 94(1)(b) is evidence of a comprehensive history of medical investigation and examination of the impairment. In that context, diagnosis may

Importantly, the Tribunal also confirmed that assessment of impairment for an applicant was function-based.¹¹⁹ The Tribunal therefore found that further treatment was only *one* consideration in the award of a DSP under the governing legislation; it was not determinative.¹²⁰

In summary, in *Thomson* there was no evidence that the further 'treatment' proposed by the Department's medical experts for Ms Thomson's chronic pain condition would result in significant functional improvement.¹²¹ In fact, the evidence suggested that improvement was unlikely even with the treatments proposed by the Department's medical expert.¹²² The medical expertise for Ms Thomson in comparison included a lengthy history of impairment from chronic pain, including multiple and continuing presentations for the treatment of Ms Thomson's chronic pain condition over many years with little success. Ms Thomson also produced clear medical opinions that there was no 'quick fix' for her condition, that it was likely to persist for more than 24 months and that her condition was not likely to improve substantially in the near future.¹²³ There was also general evidence from the medical experts in the case for both sides that there is a 'well-recognised potential lack of effective treatment' for chronic pelvic pain and that medical treatment for women experiencing chronic pelvic pain 'often does not resolve the patient of their pain to allow them full and unrestricted function'.¹²⁴

Although the findings in *Thomson* appear to be very encouraging for women who have chronic pain, it must be remembered that the Tribunal made clear that the result was heavily predicated on Ms Thomson's particular circumstances, including the nature of the

identify the nature of the impairment rather than, necessarily, identifying a particular disease or cause of impairment, even though that would commonly be the case. It follows, that subparagraph 94(1)(b) does not require the diagnosis of a specific disease, but does require diagnosis and documentation of the nature of impairment, even if, as may uncommonly occur, the collective symptoms by which the impairment is manifest cannot be described within the label of a particular disease...' (emphasis added), *Bugno* (n 62) [38] citing *Re Hudson and Secretary, Department of Family and Community Services* [2000] AATA 502 in support.

¹¹⁹ Function-based can be distinguished from diagnosis-based. For example, in *Thomson* (n 2) [54], it was found that, to adopt a diagnosis-based approach would 'run counter to a purpose and general design principle of the Tables' that are function-based, not diagnosis-based. To find otherwise would render a chronic pain condition a condition of last resort, a proposition that had been clearly rejected by earlier authority: see *Thomson* (n 2) [55], citing *Harris FCA* (n 114) [17] (Gyles J), approved on appeal in *Harris FFC* (n 114) [37] (French, Tamberlin and Rares JJ). How to address the specific criteria that go to the issue of the functional capacity of the applicant is discussed below in Part III B.

¹²⁰ *Thomson* (n 2) [42]. The statutory framework enables the AAT to consider whether any recommended treatment can reliably be expected to result in a 'substantial improvement' in the applicant's functional capacity. It is permissive then in that sense: see s 4(7), Impairment Tables.

¹²¹ *Thomson* (n 2) [74].

¹²² Thus, the functional impairment caused by her chronic pain was likely to persist for more than 2 years: *Thomson* (n 2) [68]–[74]. This is also relevant to assessing whether the applicant's condition has 'fully stabilised'. For a detailed discussion of that criterion see Part III B.

¹²³ *Thomson* (n 2) [74].

¹²⁴ *Ibid.*

evidence that had been presented in her claim (including the futility of a further laparoscopy) and the specific way in which she had proved her health condition (chronic pain rather than endometriosis).¹²⁵ Further, the Department's errors on its evidence also ultimately counted against it, since it was bound by the expert evidence it relied on, including all of its deficiencies.¹²⁶ The Department is likely to fix those evidential errors in future cases. The Tribunal also warned that in other cases further reasonable diagnostic procedures (such as laparoscopy) might operate as a bar to a claim if the procedure could 'be reasonably expected to confirm the applicability of a medical condition that was then thought likely to be the underlying cause of the chronic pain, albeit a condition not then fully diagnosed'.¹²⁷

Ms Thomson succeeded in her claim because she had a multitude of evidence from various medical experts that specifically addressed the issue of whether the impairment from her pain condition was likely to 'substantially improve' over the next two years based on any treatment that had been recommended by the Department's expert. By way of contrast, the medical evidence relied on by the Department was lacking in many respects, including that the medical experts used terms like 'temporary' to denote a condition that had already persisted for more than a year in Ms Thomson's case, as well as providing equivocating statements about the likelihood of the success of the treatments that were being recommended. For example, the medical expert said that the recommended treatments of laparoscopy (and progesterone therapy) would 'hopefully improve' Ms Thomson's pain levels.¹²⁸ This did not indicate a high degree of certainty that the recommended treatment would have any impact.¹²⁹

The key lesson from *Thomson* appears to be that an applicant may have a greater chance of succeeding in her application for a DSP by having her medical expert/s clearly address why undertaking any form of treatment (particularly any treatment recommended by the Department's medical experts) is not likely to result in any substantial

¹²⁵ Ibid [44].

¹²⁶ Ibid [45]. As noted, this included that the Tribunal was able to find that the 'treatment' of laparoscopy proposed in Ms Thomson's case was diagnostic only in nature. The other treatment (hormonal treatment) was not explained on the evidence either: *ibid*. The contentious issue of whether hormonal treatment is a 'reasonable treatment' is discussed further below.

¹²⁷ *Thomson* (n 2) [51], [52]. In Ms Thomson's case a laparoscopy had only recently been undertaken by her, with no firm conclusions able to be drawn from that procedure anyway.

¹²⁸ *Thomson* (n 2) [76]. The Department's expert's opinion was that excision of abnormal tissue was 'usually adequate ... to resolve symptoms of endometriosis in most patients', *ibid*. This is hardly a resounding endorsement of the efficacy of the proposed treatment in Ms Thomson's particular case.

¹²⁹ *Thomson* (n 2) [76]. As already discussed, the Tribunal was able to find that yet another laparoscopy was not likely to result in any substantial improvement to Ms Thomson's functional capacity, particularly because she had only recently undertaken that procedure with very little improvement in her symptoms.

improvement in her pain levels and functional capacity. It is also recommended that, as in *Thomson*, consideration is given by the applicant and her legal and medical experts as to whether a claim could be made on the basis of a 'chronic pain' condition, rather than a claim based on 'endometriosis'. If an applicant does argue that her condition is endometriosis, she still needs to adduce her own expert evidence that clearly addresses why any form of treatment proposed by the Department, including laparoscopy if that is suggested, is not a reasonable treatment in her particular case.

(b) Is Hormone Therapy a 'Reasonable Treatment'?

Hormone therapy for endometriosis involves the use of progesterone. The underlying theory of this treatment is that higher levels of progesterone will stop endometrial deposits from regrowing, thus reducing the likelihood of further pain or requiring further surgery to excise endometrial deposits.¹³⁰

Progesterone therapy was the second 'reasonable treatment' recommended by the Department's expert in the case of *Thomson*.¹³¹ This was a treatment for a condition (endometriosis) that had not been diagnosed in Ms Thomson's case and on which she was not relying in support of her DSP application.¹³² On that basis, the Tribunal rejected the proposition that Ms Thomson had refused to undertake reasonable treatment of her chronic pain condition by not undertaking progesterone therapy.¹³³

The Tribunal's position was obviously a positive result for Ms Thomson. As has been seen, however, the result was predicated on the basis that chronic pain was the underlying condition Ms Thomson was claiming, not endometriosis. What would happen if the underlying condition was endometriosis? Would progesterone therapy still be considered a 'reasonable treatment' for a woman to have to undergo? Such an argument would be interesting given some of the concerns that have already been expressed about the use of hormonal treatments.¹³⁴ For example, the use of hormonal treatments in managing paedophilic urges in convicted paedophiles has been challenged by lawyers and doctors as being a breach of the human rights of those (mainly) men.¹³⁵ Progesterone treatment is a form of chemical castration and has been

¹³⁰ Abdul Kadir Abdul Karim et al, 'Reviewing the Role of Progesterone Therapy in Endometriosis' (2019) 35(1) *Gynaecological Endocrinology* 10, 11–14.

¹³¹ *Thomson* (n 2) [76].

¹³² *Ibid* [36].

¹³³ *Ibid*.

¹³⁴ See, eg, John McDonald Wilson Bradford, 'The Treatment of Sexual Deviation using a Pharmacological Approach' (2000) 37(3) *The Journal of Sex Research* 248; Gajendra Goswami, 'Castration Laws: Marching Towards Imperfect Justice' (2014) 82(2) *Medical Legal Journal* 70.

¹³⁵ Goswami (n 134).

argued to be a breach of human rights in that context.¹³⁶ As has been noted ‘the associated health hazards with anti-libido drugs put a question mark on such State sponsored penal response. Castration destroys human dignity, breaches the right of privacy and procreation and attracts the cruel and unusual punishment clause’.¹³⁷ Progesterone therapy for women is described as being ‘an anthropogenic procedure by which a woman loses the functions of her ovaries’.¹³⁸ That is, chemical castration.¹³⁹

Apart from considering existing uncertainty in the medical literature surrounding the effective use of such therapy to effectively treat endometriosis and the pain it causes,¹⁴⁰ future cases might also direct their evidence to addressing why a therapy that appears to be an unacceptable treatment for persons who commit criminal acts is nonetheless potentially acceptable as a required (reasonable) treatment for women with endometriosis or chronic pelvic pain. Although it is beyond the scope of this article to consider the human rights and medical implications of mandating this form of treatment for any health condition, one can question whether it would be appropriate if the price to be paid for obtaining a DSP is submitting to a form of chemical castration as a ‘reasonable’ form of treatment. It is arguable that acceptance of the use of this type of therapy is really a matter for the individual woman and her treating physician/s to weigh up, taking into account all the potential health and other impacts on her life that may be created by the use of progesterone in her specific case, including current uncertainty as to its efficacy. At this point, it remains open to applicants to argue that such therapy is not appropriate in their individual case, taking into account the guidance provided by the Tribunal following decisions of the Federal Court in this area. Applicants might also consider addressing the concerns expressed by the medical academy and the legal profession about the use of such therapy more generally, particularly if there is any suggestion that such a treatment should be forced on a woman against her will as a precondition to relief. No matter what, an applicant will need to ensure that her medical expert addresses why the treatment is or is not reasonable in her circumstances, including whether it would lead to any significant improvement in her functional capacity in any event.

¹³⁶ On the approach to this treatment for sexual deviancy see Bradford (n 134). On the argument as to human rights violations in using this treatment (chemical castration) based on many considerations, including its severe side effects see Goswami (n 134) 74–77. Goldblatt and Steele have also raised interesting rights issues in relation to the use of sterilisation on women in other contexts: (n 34) 310–315.

¹³⁷ Goswami (n 134) 70.

¹³⁸ *Ibid.* For the treatment of endometriosis, the medical profession uses (along with other treatments) medroxy-progesterone acetate (usually sold as ‘Depo-Provera’).

¹³⁹ Goswami (n 134) 70.

¹⁴⁰ For a recent analysis see Abdul Kadir Abdul Karim et al (n 130) 11–14.

(c) *What Happens if an Applicant does not Pursue all Available (Conventional) Medical Treatments?*

As discussed above, not relying on the recommendations or evidence of accepted medical practitioners may weigh against an applicant in trying to establish that her condition has been 'fully diagnosed'.¹⁴¹ Failing to see such practitioners for ongoing treatment can also count against an applicant in trying to establish that her condition has been 'fully treated'.

In *Bugno*, the Tribunal determined that the primary cause of Ms Bugno's current condition was her refusal to follow accredited medical treatments for her depression. The Tribunal's finding was that it had not been 'satisfied that the treatments Ms Bugno chose to decline, such as psychological counselling, anti-depressant medication and systematic medical assessment of her health status, were not reasonable treatment [sic] for her in the circumstances'.¹⁴² This appears to have been based on the opinion of one doctor whom Ms Bugno had seen at the Department's direction. That doctor opined that, despite the 'absence of any clinical data including investigations', the doctor 'felt' that Ms Bugno's 'symptoms of depression is [sic] a major contributory factor to her present condition'.¹⁴³ The reasons given by Ms Bugno for having totally given up on conventional medical treatment were seemingly not afforded much weight. The Tribunal opined that there was no acceptable evidence of Ms Bugno's reasons for not seeking further conventional medical treatment, even though Ms Bugno had set out her specific concerns in her evidence.¹⁴⁴ In the absence of any relevant expert opinion (from a treating psychiatrist or psychologist) to support Ms Bugno's position that it was reasonable for her not to consult accredited medical practitioners, the AAT found that Ms Bugno had 'chosen to decline' reasonable treatments that she should have pursued.¹⁴⁵

It can be observed that this approach places many sufferers of endometriosis and chronic pelvic pain in what looks very much like a 'Catch-22'. A woman stops seeing conventional treating physicians because conventional treatments over many years have failed her or made her feel worse. To establish why she no longer wishes to see those conventional health practitioners (who have already ignored and failed

¹⁴¹ See above at Part III A 1 (d) on this point.

¹⁴² *Bugno* (n 62) [50]. It is not clear whether there was any evidence before the Tribunal of the efficacy of counselling to treat long-term pain caused by endometriosis in any event. This appears to have been assumed to be a useful treatment for endometriosis based on the report by the Department's expert.

¹⁴³ *Bugno* (n 62) [31], where it was found that Ms Bugno 'declines medical management of her condition other than by alternate medical therapists'.

¹⁴⁴ *Bugno* (n 62) [44]. For example, Ms Bugno had even deposed that many of the diagnostic procedures she had already been subjected to had made her physically unwell: see *ibid* [20].

¹⁴⁵ *Ibid* [50].

her), the applicant must nonetheless submit herself to assessment by another conventional health practitioner who may dismiss her pain as being psychosomatic.¹⁴⁶ Certainly, the Department's expert attributed Ms Bugno's pain to a depressive illness instead of endometriosis. That underlying untreated chronic pelvic pain may have been *the cause* of Ms Bugno's depression in the first place, as well as her reluctance to pursue further treatments with conventional specialists, was not taken into account by the medical expert or, in the end, by the Tribunal. This is no specific criticism of the Member in *Bugno* who may have had no knowledge of the ample literature on women in pain, gender bias and resulting attribution errors in diagnosis and management of real health conditions by the medical profession. The much more problematic part of the Member's finding in *Bugno* is that it does appear to have been based on a medical report in which the expert had himself conceded that he could not express a concluded view on Ms Bugno's position, given the limited state of the medical records and tests the expert had access to at the time of the assessment.

The glimmer of hope that has been offered to applicants is that the Impairment Tables allow an applicant to adduce evidence on why a treatment is not suitable in her case, although this will not obviate the fear an applicant may well have in approaching another physician for assessment of her situation. The catch is that an applicant must have an accredited medical practitioner provide this evidence. The Tribunal in *Bugno* did note that s 4(6) of the Impairment Tables allows the Tribunal to consider whether there 'is a medical or other compelling reason for the person not to undertake reasonable treatment'.¹⁴⁷ This might include evidence from an acceptable treating physician addressing why the applicant is no longer able to pursue recommended forms of treatment in her particular case. It appears that an applicant who does not wish to pursue treatment with an accredited medical practitioner must adduce evidence from a psychiatrist or psychologist as to why she cannot pursue conventional medical treatments any further. That evidence may involve the medical expert addressing matters such as any anxiety or trauma that are likely to be caused if the applicant is required to subject herself to further recommended treatments. Such evidence may be seen as part of a medical expert addressing why any further, conventional treatments will not be likely to result in an improvement in the applicant's functional capacity and can include whether the recommended treatments would be likely to result in a further reduction of the applicant's functional capacity by causing her further health problems, including mental health problems.

¹⁴⁶ For example, see Samulowitz et al (n 11); Armitage, Schneiderman and Bass (n 14); Fillingim (n 11); Greenspan et al (n 11); Colameco, Becker and Simpson (n 14); Redman et al (n 14); Oakley (n 14); Fee (n 14); Mackey and Diercks (n 14); Ayanian and Epstein (n 14).

¹⁴⁷ *Bugno* (n 62) [49]–[50].

(d) Is the Cost of a Recommended Treatment, or Ease of Access to a Treatment, Relevant?

One further matter that has not come up directly in decisions to date, but which an applicant might also wish to call evidence on, is the applicant's financial capacity to obtain any 'reasonable treatment'. The Impairment Tables make clear that an applicant can provide evidence as to why any potential treatment is beyond her means to achieve, either because it is not available at a location reasonably accessible to the applicant or not available to her at a reasonable cost.¹⁴⁸ Since evidence suggests that women who have endometriosis in rural and regional areas of Australia, in particular, are at a significant financial disadvantage when it comes to obtaining treatment for their condition, this may be a relevant consideration to address in those cases.¹⁴⁹

B *Failure to Satisfy the Tribunal that the Condition is Fully Stabilised*

As discussed in Part III, this criterion must be made out as part of establishing that the applicant's health condition is 'permanent'.¹⁵⁰ The applicant needs to call evidence (including expert evidence) that addresses that she currently has a (severe) functional impairment of 20 points or more under the applicable Impairment Table.¹⁵¹ To qualify as having a functional impairment of 20 points or more, the first requirement is that at least two of the following four matters need to be established: (1) that the applicant's attention and concentration at a task was frequently (at least once every hour) interrupted or reduced by chronic pain or other symptoms or personal care needs associated with her condition; (2) that the applicant was not able to sustain work activity or other tasks for a total of more than 3 hours a day, even with regular breaks, due to the symptoms of her condition; (3) that the applicant's condition could affect the comfort or attention of co-workers; (4) that the applicant was frequently (twice or more per month) absent from work, education or training activities due to her condition.¹⁵²

The second requirement that an applicant must prove is that the identified functional impact/s of her condition are 'not likely to substantially improve with treatment within the next two years' such that she will be able to 'engage in work'.¹⁵³ Claims have failed because

¹⁴⁸ Section 4(7), Impairment Tables.

¹⁴⁹ Ernst & Young (n 8) 22–23.

¹⁵⁰ Under s 6(3) of the Impairment Tables.

¹⁵¹ As already noted, the relevant Impairment Table for endometriosis is Table 10 (dealing with reproductive conditions). See (n 45) and *Thomson* (n 2) [84].

¹⁵² Hereafter described as the 'Four Considerations'. See Table 10, Impairment Tables (extracted in Appendix 1).

¹⁵³ As noted in Part II of this article, s 4(6) of the Impairment Tables provides that a 'condition is fully stabilised if the applicant can undertake reasonable treatment and that treatment is likely

there is insufficient evidence on any one of these matters. For the remainder of this Part, I consider the specific evidential hurdles an applicant with endometriosis or chronic pelvic pain is likely to face in proving (a) that she is operating under a level of functional impairment of 20 points or more under the Impairment Table and (b) that, even with treatment, her function is not likely to improve within the next two years such that she will be able to engage in work of more than 15 hours per week.

1 *Insufficient Evidence of Functional Impairment*

Two decisions of the AAT establish that any evidence called by the applicant needs to address in enough detail what the functional impacts are of her condition. These include the decisions in *Polat* and *QMIL*.

In *Polat*, the applicant's doctor opined that the applicant had 'severe pelvic endometriosis with chronic pelvic pain' and that her 'chronic pain consistently limits her abilities to work'.¹⁵⁴ He said that this was 'in keeping with patients suffering from this condition'.¹⁵⁵ The medical opinion however provided no detail on what the actual functional impacts of the condition were on her. The opinion certainly did not provide any detailed breakdown of the impacts of Ms Polat's condition by reference to the four criteria set out in the applicable Impairment Table. This type of opinion lacks clarity because it does not clearly address the statutory criteria. Not surprisingly, the Member¹⁵⁶ in *Polat* found that there was insufficient evidence that Ms Polat usually experienced 'fatigue when performing light physical activities' or was 'unable to undertake one or more of the tasks listed under the descriptor for 'severe functional impairment' in the relevant Table.¹⁵⁷ Thus, even though the Member accepted that Ms Polat had undergone a number of surgical procedures to treat her endometriosis and suffered from 'significant pelvic pain',¹⁵⁸ her claim was rejected because the expert evidence failed to clearly address the functional impact of Ms Polat's condition on her.

A similar finding was made in *QMIL*. In that decision the Tribunal¹⁵⁹ found that it could not be satisfied that the evidence demonstrated that the applicant's endometriosis 'had a functional impact on the Applicant', even though it was acknowledged that 'the pain over time has been quite disabling'.¹⁶⁰ A further difficulty in

to result in significant functional improvement to a level enabling the person to undertake work in the next 2 years'.

¹⁵⁴ *Polat* (n 62) [19].

¹⁵⁵ *Ibid.*

¹⁵⁶ Senior Member A K Britton.

¹⁵⁷ *Polat* (n 62) [20].

¹⁵⁸ *Ibid* [19].

¹⁵⁹ Senior Member Dr Cremean.

¹⁶⁰ *QMIL* (n 62) [30].

QMIL was that the applicant had more than one condition and the expert evidence was not clear about which condition was causing what functional impact on the applicant in any event.¹⁶¹

Applicants in future cases might consider making sure that the expert evidence they adduce clearly addresses the functional impact on her of a specific claimed condition. This should be done by clear reference to the statutory criteria. If the applicant suffers from more than one health condition, the evidence needs to clearly address whether the claimed condition has caused any functional impairment to the applicant. This needs to be done by reference to at least two of the Four Considerations set out in the Table.

2 Addressing the Four Considerations

As noted above, part of establishing that an applicant's condition is permanent is first establishing that there has been a functional impact on her of 20 points or more. This is done by addressing at least two of the Four Considerations listed in Table 10.

Ms Thomson's case provides a very good example of how evidence can be presented to the Department or the Tribunal to ensure that there is clear and sufficient evidence that addresses the required criteria. In (a) to (c) below I analyse how Ms Thomson went about addressing each one of these relevant considerations and what guidance the Tribunal has provided on some of the key issues that can arise in claims by applicants with chronic pelvic pain or endometriosis. These considerations can be broadly grouped as follows:

- (a) What constitutes 'work' for the purpose of the Four Considerations and the applicable Impairment Table?
- (b) Does undertaking a course of study necessarily preclude an applicant from making a claim?
- (c) How can an applicant prove interruptions to her concentration caused by her condition?

(a) What Constitutes 'Work'?

A definition of 'work' is relevant to two of the Four Considerations, and to the Impairment Table more generally, in establishing that the applicant's condition has 'fully stabilised'. Addressing this consideration includes proving the required level of functional impairment under the Table. That is, first, the applicant was not able to

¹⁶¹ Ibid. The applicant had given evidence that, even though her endometriosis was a long-standing condition (she was 18 years of age when symptoms began; she was 54 at the time of her application for a DSP) her other conditions caused her more difficulties, *QMIL* (n 62) [25]. The Member said that they were 'unable on the evidence to make a finding that her [the applicant's] condition, as opposed to any other of her conditions, impaired her functioning in a way which could lead me to assign a points rating', *ibid* [30].

sustain work activity or other tasks for a total of more than 3 hours a day, even with regular breaks, due to the symptoms of her condition; and second, that the applicant was frequently (twice or more per month) absent from work, education or training activities due to her condition. As noted above, this definition is also relevant to establishing that her condition is not likely to substantially improve with treatment within the next two years such that she will be able to ‘engage in work’.

In *Thomson*, the Department denied the applicant’s claim on the basis that she met none of the statutory criteria. The argument was based on the facts that, first, Ms Thomson was undertaking part-time study at university; second, she worked 8 hours per week as a nanny; and third, she also undertook volunteer work often in excess of 3 hours on a regular basis.¹⁶² The Tribunal rejected the Department’s arguments that Ms Thomson could ‘work’ more than 15 hours per week. The claim the Department made was that, because Ms Thomson undertook volunteer work each week, this indicated that she did not have enough functional impairment to meet the required level of impairment under the Table of not being capable of working more than 3 hours per day.¹⁶³

The AAT made it clear that unpaid, volunteer work is not ‘work’ for the purpose of assessing the applicant’s ability to undertake work.¹⁶⁴ ‘Work’ in this context means work that exists in Australia of at least 15 hours per week at or above minimum wage and independently of a program of support.¹⁶⁵ In other words, ‘work’ for this purpose means work undertaken ‘in the context of a normal, open, workplace’, not work for a ‘benign employer’.¹⁶⁶ Helpfully, Ms Thomson’s medical expert evidence also directly addressed the point, noting that Ms Thomson had only been able to undertake her volunteer work due to a ‘very supportive employer’ and that he ‘could not imagine that Ms Thomson currently presents as a candidate for regular, commercially sustainable employment’.¹⁶⁷ Further, even the Department’s own medical expert doubted Ms Thomson’s capacity to work, even with sufficient breaks.¹⁶⁸ The Tribunal also acknowledged that the evidence established that her pain condition could often flare up and increase her

¹⁶² *Thomson* (n 2) [87].

¹⁶³ *Ibid* [102]. The Department said that Ms Thomson had a capacity to work for more than 15 hours per week because she performed ‘other tasks’ in addition to her study and her volunteer work, including that she worked as a nanny (which was paid). There was no evidence that she could perform her work as a nanny for more than 8 hours per week in any event, *ibid*.

¹⁶⁴ *Thomson* (n 2) [98]. The Tribunal ultimately also rejected the proposition that undertaking unpaid, volunteer work was a ‘work activity’ within the meaning of the term ‘work’ employed in the ‘continuing inability to undertake work’ test under SSA (n 1) s 94(1)(c).

¹⁶⁵ *Thomson* (n 2) [114]. The Tribunal pointed out that the Department had already accepted that it was necessary to disregard ‘the existence of a benign employer or sheltered or special employment’ in this context: *Thomson*, (n 2) [114].

¹⁶⁶ *Ibid* [114].

¹⁶⁷ *Ibid* [108].

¹⁶⁸ *Ibid* [107].

pain.¹⁶⁹ These flare ups were unpredictable and made 'commercial employment' on a regular basis much less likely for her.¹⁷⁰ This is in keeping with much of the evidence of the impacts of endometriosis and chronic pelvic pain.¹⁷¹ The unchallenged evidence before the Tribunal was thus that Ms Thomson's unpaid volunteering was limited to 3 hour shifts every fortnight. The Tribunal found that this could not fit the definition of a capacity to sustain, without interruption, daily shifts of 3 or more hours' duration.¹⁷² This was supported by evidence (again, not challenged by the Department) presented by Ms Thomson that her volunteer shifts were in fact often interrupted (either missed or shortened) because she was unwell.¹⁷³ The AAT found that Ms Thomson's claim that she could not 'work' for the requisite number of hours per week would be capable of succeeding on this basis alone.¹⁷⁴

The key to Ms Thomson's arguments succeeding included the evidence she presented from her employers (including employers where she had undertaken both paid and unpaid work) that her condition frequently interrupted her ability to 'work' without interruption for long enough to be able to sustain 'commercial employment' of more than 3 hours per day. This was corroborated by her medical expert professing his opinion that her condition made any form of regular work unlikely in the next 2 years.

The lesson for applicants is to call as much evidence as possible from employers, co-workers and treating doctors on the functional impact of a condition on the applicant's ability to work. The decision in *Thomson* does make clear that merely having a volunteer role does not mean that an applicant will be found to be capable of 'working' for more than 3 hours per day. If challenged, applicants may also wish to consider calling evidence from a medical expert in relation to whether carrying out volunteer work assists the applicant to maintain a more positive mental state, particularly given that the Department's medical experts in the past have expressed views that avoiding depression is part of the 'reasonable treatment' options for treating pain.¹⁷⁵

(b) Undertaking a Course of Study

In *Thomson*, the Tribunal also comprehensively rejected the idea that being well enough to undertake a course of study necessarily precluded meeting the requisite level of functional impairment under Impairment Table 10.¹⁷⁶ The AAT found that the evidence called by Ms Thomson

¹⁶⁹ Ibid [130].

¹⁷⁰ Ibid.

¹⁷¹ See Part I of this article for further details of these impacts.

¹⁷² *Thomson* (n 2) [99].

¹⁷³ Ibid [100].

¹⁷⁴ Ibid [99], that is, even if the AAT's interpretation of the definition of 'work' was wrong.

¹⁷⁵ On this point, see the discussion above on the value of this evidence in *Bugno* (n 62) [31].

¹⁷⁶ *Thomson* (n 2) [103]–[105].

established that her functional capacity had been impaired to such an extent that she had even had to approach her University to put in place a disability inclusion plan to accommodate the functional impairment her chronic pain had caused to her ability to study.¹⁷⁷ In any event, the evidence did not establish that Ms Thomson was undertaking her education for more than 3 hours per day, particularly not on a ‘repetitive or habitual basis’.¹⁷⁸ All of the evidence Ms Thomson produced from her University and her treating specialist provided yet further support for her claim of the severe functional impairment caused by her chronic pain.

Importantly for applicants in future claims, the Tribunal noted that the legislature did not intend to prevent applicants from undertaking educational tasks to qualify for a DSP. In fact, the statutory scheme specifically contemplated that an impairment should not prevent a person from undertaking a training activity.¹⁷⁹ Thus, educational pursuits should not act as a bar to a claim for a DSP.¹⁸⁰

The key lessons for future applicants are that (1) undertaking a course of study is not fatal to a claim for a DSP, however (2) applicants should keep detailed records (medical records and communications to and from their educational institution) of any time away from their studies, any changes to enrolment mode (from full time to part time or leave of absence) as well as any disability plans or reasonable accommodations made by the University to accommodate the functional impact caused by a condition on the applicant’s capacity to study. All of these matters can constitute relevant evidence in support of a claim that an applicant meets the requisite level of functional impairment under Impairment Table 10.

(c) Proving Interruptions to Concentration caused by a Health Condition

One of the relevant considerations under the Four Considerations in Impairment Table 10 includes that the applicant’s ‘attention and concentration at a task was frequently (at least once every hour) interrupted or reduced by chronic pain or other symptoms or personal care needs associated with her condition’.

¹⁷⁷ Ibid [116]–[117]. Ms Thomson had disclosed to the University (with supporting medical evidence) that her pain reduced her concentration levels. The applicant also presented medical evidence to the AAT that part of her education had been interrupted altogether by her pain condition, and that she had had to alter her mode of enrolment from full-time to part-time. Ms Thomson had also been hospitalised at various times. The University had accepted the evidence put to them by Ms Thomson and had put in place a plan for her to undertake a part-time mode of study as well as provision for additional time for tests and for toileting during tests, quizzes and exams, *ibid* [92].

¹⁷⁸ Ibid [105], relying on the Guidelines, s 3.6.3.05 and s 11(3), Impairment Tables.

¹⁷⁹ Ibid [104], citing SSA (n 1) s 94(2).

¹⁸⁰ *Thomson* (n 2) [104].

In *Thomson*, the Department argued that Ms Thomson's concentration was not frequently interrupted by her pain condition. In rejecting this argument, the Tribunal found that there was ample, indirect, corroborating evidence of the impact on her concentration levels from the medical evidence she had placed before the Tribunal. Specific evidence from medical experts about her disrupted sleep and daytime fatigue was presented to the AAT and provided further corroboration of her claim.¹⁸¹ In addition to the medical evidence, Ms Thomson also produced evidence of direct observations from people in her life (including her employers) on the impact of the pain on her, including the effect that her pain medications had on her day-to-day performance. The Department also ran a curious argument that, because the applicant had not kept a day-to-day record of the impacts of her pain, she had not produced sufficient evidence of the impact of her condition on her. The Tribunal dismissed this argument on the basis that it was hardly surprising that a person who experiences chronic pain would not be able to keep a daily record of this kind and, in light of the other extensive evidence Ms Thomson had produced, this could not be fatal to her claim in any event.¹⁸²

The lesson here for future applicants is to adduce as much corroborating evidence as possible of the impacts of the pain on their day-to-day functions, both from treating doctors and from other persons the applicant is in contact with on a daily basis, including employers where possible. Family members might also provide supporting evidence, however they may not be seen as having a requisite degree of independence in comparison to third parties like employers and colleagues, or treating physicians. Further, any medical evidence relied upon by an applicant should emphasise that the applicant's attention to, and concentration on, tasks she is required to undertake as part of her work has been frequently (at least once every hour) interrupted or reduced by chronic pain or other symptoms or personal care needs associated with the condition. Such evidence would preferably be provided by the applicant's current treating physicians, who have access to the applicant's medical history. The medical evidence could also be supported by evidence from employers. If an applicant is undertaking a course of study, the medical evidence might also be supported by teachers or other staff of the educational institution. Any expert report would, ideally, specifically address the applicant's inability to concentrate caused by her symptoms and/or her need to

¹⁸¹ Ibid [91].

¹⁸² Ibid [89]. Applicants could consider keeping a diary of the constant interruptions their condition causes them (they could produce this to their treating doctor in the first instance for incorporation in any medical report). There are simple tables in some endometriosis support books that help patients with convenient, 'tick-a-box' lists of symptoms. See, eg, Kerry-Ann Morris, *Living Well with Endometriosis* (2006, Harper Collins) 266–269.

attend to symptoms of her condition each hour. Although the AAT in *Thomson* accepted that the effect of a chronic pain condition was that it greatly reduced an applicant's ability to concentrate,¹⁸³ applicants should consider the value of specifically stating this in an expert report to avoid any debate on the matter.

3 *Addressing whether Treatment will Result in Functional Capacity within the Next Two Years*

As noted above, as part of proving that her condition is permanent, an applicant needs to establish that the functional impact/s of her condition are not likely to substantially improve with treatment within the next two years such that she would be able to engage in work.¹⁸⁴ An applicant needs to ensure that her evidence clearly addresses whether any treatments for her condition, particularly any treatment recommended by an expert for the Department, would be likely to result in any significant functional improvement for her.¹⁸⁵ It is also relevant to establish that her condition has 'fully stabilised'. *Bugno* is a good example of what happens where expert evidence is not clear on this point.

The Tribunal in *Bugno* rejected the applicant's claim for a DSP on a number of bases, including that Ms Bugno did not provide enough evidence from accredited doctors as to whether her impairment from endometriosis was 'stable or susceptible to improvement by treatment within' the relevant 2 year period.¹⁸⁶ It determined that the applicant's condition had not 'fully stabilised' based on the evidence of one expert in this respect.¹⁸⁷ This conclusion as to Ms Bugno's condition was made despite the caveat in the expert's evidence about his ability to provide a conclusive opinion based on the information before him at the time.¹⁸⁸ In the absence of any other expert evidence on the point however, the Tribunal used that opinion to conclude that the applicant's condition had not fully stabilised. The paucity of recent expert evidence from an accredited specialist on Ms Bugno's current capacity ultimately counted against her.

In *Thomson*, the AAT took a much stricter approach to the Department's evidence as to whether any proposed treatment was likely to result in any improvement of Ms Thomson's capacity in the next 2

¹⁸³ *Thomson* (n 2) [91].

¹⁸⁴ See Part II of this article for further discussion.

¹⁸⁵ The point has already been made that this evidence is also relevant to establishing that the applicant has undertaken reasonable treatments for her condition. See the discussion in Part III A 2.

¹⁸⁶ *Bugno* (n 62) [45].

¹⁸⁷ *Ibid* [39], [40], [42]. As noted, that expert had expressed the opinion that the applicant's condition had not stabilised whilst, at the same time, saying that he could not provide a definitive opinion unless further medical records were obtained, *ibid* [31].

¹⁸⁸ The expert said that Ms Bugno 'should be recovered in 6/12 [months]', *ibid*.

years. The Department's medical expert had opined that Ms Thomson's functional impairment would improve (increasing her ability to work to 15-22 hours per week) with 'disability specific interventions' in the form of 'workplace modifications, vocational counselling and post-placement support'.¹⁸⁹ However, the Department did not provide any details of what any of these interventions were, let alone any detailed evidence of how they were expected or likely to improve her functional capacity to work 15-22 hours per week.¹⁹⁰ Compounding this issue was the fact that the expert report failed to state whether any of the interventions were expected to be implemented at all, since they were expressed to be merely 'possible'.¹⁹¹ The AAT treated these vague opinions with the weight they deserved, dismissing them.¹⁹²

What lessons can applicants draw from these cases? One clear lesson is to ensure that the state of the evidence presented by the Department is carefully reviewed, with any evidential gaps being clearly highlighted for the Tribunal by the applicant. If the applicant's own doctor disagrees with the Department's medical expert/s on likely improvements to her condition from any of the recommended treatments, it is important to clearly document such disagreements (together with reasons). Applicants also need to ensure that any expert opinion they seek to rely upon is up to date.

V Conclusion: Key Points and Future Directions

The cases decided by the AAT suggest that succeeding in a claim for a DSP for any woman experiencing the severest effects of endometriosis or chronic pelvic pain is a complex process. In part, this complexity is created by the statutory framework currently in place. That framework requires expert evidence on a range of specific statutory criteria. Those criteria often contain definitions within definitions. Expert medical evidence in support of a claim must also express clear opinions across each of those criteria. Women who have been so severely incapacitated and affected by endometriosis and chronic pain that they need to apply for a DSP, are likely to have a long and complex history for their condition. The medical evidence needs to take that history into account, whilst also providing more recent opinion on the conclusions that can be drawn from that history. This is not necessarily a straightforward report to write for any treating doctor who is usually busy treating patients in their practice instead of acting as a full-time provider of medical reports. Despite these difficulties, an applicant benefits greatly from ensuring that she finds an accredited and well-respected medical

¹⁸⁹ *Thomson* (n 2) [121].

¹⁹⁰ *Ibid* [122], [124], [126].

¹⁹¹ *Ibid* [124].

¹⁹² *Ibid* [121].

expert who can provide a detailed opinion that addresses each of the relevant statutory criteria and rebuts any problems with the Department's own medical assessment. All of this is undertaken at the applicant's expense. Whether any woman with severe chronic pelvic pain can achieve all of this seems rather doubtful when the evidence of the debilitating impacts of endometriosis, both personal as well as financial (as discussed in Part I), are considered.

Professor Carney has analysed in detail how successive Commonwealth Governments have made it ever more difficult for applicants to obtain any form of disability pension.¹⁹³ This certainly appears to remain the case for women with endometriosis and chronic pelvic pain. To date, it appears that women who experience endometriosis' most debilitating effects are still being asked to subject themselves to a complex and costly process to obtain a DSP, one which their own pain can prevent them from effectively navigating successfully in most cases. There is a real question as to whether this is an appropriate approach, given that the Commonwealth has now both documented and accepted the extensive impacts on the lives of women with endometriosis in Australia.

¹⁹³ On the nature of the continuing withdrawal of disability support by the Commonwealth over decades see Carney (n 7).

Appendix 1: Digestive and Reproductive Conditions

Social Security Act 1991 (Cth) Table 10 — Digestive and Reproductive Conditions

Points	Descriptors
0	<i>There is no functional impact on work-related or daily activities due to symptoms or personal care needs associated with a digestive or reproductive system condition.</i> (1) The person is not usually interrupted at work or other activity by symptoms or personal care needs associated with a digestive or reproductive system condition.
5	<i>There is a mild functional impact on work-related or daily activities due to symptoms or personal care needs associated with a digestive or reproductive system condition.</i> (1) At least one of the following applies: (a) the person's attention and concentration at a task are sometimes (on most days) interrupted or reduced by pain or other symptoms or personal care needs associated with the digestive or reproductive system condition; or (b) the person is sometimes (less than once per month) absent from work, education or training activities due to the digestive or reproductive system condition.
10	<i>There is a moderate functional impact on work-related or daily activities due to symptoms or personal care needs associated with a digestive or reproductive system condition.</i> (1) At least two of the following apply to the person: (a) the person's attention and concentration on a task are often (at least once a day but not every hour) interrupted or reduced by pain or other symptoms or personal care needs associated with the digestive or reproductive system condition; (b) the person is unable to sustain work activity or other tasks for more than 2 hours without a break due to symptoms of the digestive or reproductive system condition; (c) the person is often (once per month) absent from work, education or training activities due to the digestive or reproductive system condition.

20	<i>There is a severe functional impact on work-related or daily activities due to symptoms or personal care needs associated with a digestive or reproductive system condition.</i> (1) At least two of the following apply to the person: (a) the person's attention and concentration at a task is frequently (at least once every hour) interrupted or reduced by pain or other symptoms or personal care needs associated with the digestive or reproductive system condition; (b) the person is unable to sustain work activity or other tasks for a total of more than 3 hours a day, even with regular breaks, due to symptoms of the digestive or reproductive system condition; (c) the person's condition may affect the comfort or attention of co-workers; (d) the person is frequently (twice or more per month) absent from work, education or training activities due to the digestive or reproductive system condition.
30	<i>There is an extreme functional impact on work-related or daily activities due to symptoms or personal care needs associated with a digestive or reproductive system condition.</i> (1) At least two of the following apply to the person: (a) the person's attention and concentration at a task are continually interrupted or reduced by pain or other symptoms or care needs associated with the digestive or reproductive system condition (e.g., pain or other symptoms are present all or most of the time); (b) the person is unable to sustain work activity or other task for more than 1 hour without a break due to symptoms of the digestive or reproductive system condition; (c) the nature of the person's condition is likely to affect co-workers adversely; (d) the person is rarely able to attend work, education or training activities due to the digestive or reproductive system condition.