WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3606/19**
Applicant: **Michael Taylor**
Respondent: **Mirgregar Pty Ltd t/as Kenware Products**
Date of Determination: **12 September 2019**
CITATION: **[2019] NSWWCC 301**

The Commission determines:

1. The applicant has suffered a consequential injury to his left knee, as a result of an injury to his right knee on 14 April 2010.

2. A finding that the proposed total left knee replacement surgery is reasonably necessary as a result of the injury to the applicant's right knee referred to in 1 above.

3. The respondent is to pay the reasonable costs of the applicant's proposed total left knee replacement surgery pursuant to s 60 of the *Workers Compensation Act 1987*.

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

Michael Perry
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OFMICHAEL PERRY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Jackson

Ann Jackson
Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Michael Taylor (the applicant) was employed by Mirgregor Pty Ltd (the respondent) as a warehouse manager. On 14 April 2010, he suffered a twisting injury to his right knee when exiting his car while journeying home from that employment. As a result, his right knee has since had at least five surgical procedures performed on it between 16 October 2010 and 1 June 2017 – including a total knee replacement (TKR) on 26 February 2013 and three subsequent replacement revision surgeries on 20 May 2014, 26 April 2016 and 1 June 2017.

2. The respondent has accepted liability for that right knee injury. By an Application to Resolve a Dispute (ARD), the applicant has claimed future expenses under s 60 of the *Workers Compensation Act 1987* (the 1987 act) for costs of proposed *left* TKR surgery and ancillary treatment. He alleges the left knee injury has occurred as a result of the right knee injury – by him developing an altered gait pattern and favouring the right knee.

ISSUES FOR DETERMINATION

3. The parties agree that the following issues remain in dispute:

    (a) Whether there has been a consequential injury to the applicant's left knee as a result of the accepted injury to his right knee (the first issue).

    (b) Whether the proposed surgery is reasonably necessary (the second Issue).

PROCEDURE BEFORE THE COMMISSION

4. Conciliation and arbitration occurred on 5 September 2019. Mr Tanner of counsel, instructed by Ms Ens, solicitor, appeared for the applicant. Mr Morgan of counsel appeared for the respondent. I am satisfied the parties understand the nature of the application and legal implications of any assertion made in the information supplied. I have used my best attempts to bring them to a settlement acceptable each. I am satisfied they had sufficient opportunity to explore settlement and have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Documentary Evidence

5. The following documents were in evidence before the Commission and taken into account in making this determination (subsequent numbers immediately following reference to the ARD or Reply refer to page numbers unless otherwise indicated) :

    (a) ARD and attached documents.

    (b) Reply and attached documents.

Oral Evidence

6. Each party stated there was no need to call any oral evidence or cross examine any witness.

Review of the Evidence

The Applicant (ARD 1-7)

7. The condition of the applicant's right knee was worsening by 2010 and his GP, Dr Virk, referred him to an orthopaedic surgeon, Dr Sherif Rizkallah. He was limping badly.

8. Dr Rizkallah performed a right knee arthroscopy on 16 October 2010, and the applicant :

> "continued to have a severe limp … in early 2011 … using a walking stick for support ... was limping heavily … could not carry out heavy domestic tasks … could not … walk for any distance … pain in my left knee … increasing due to favouring my right leg … was becoming severe … continued to have severe pain in my right leg … developed back pain from … limping … pain in my left knee was increasing as I continued to put most of my weight on it … after each of my right knee surgeries I had lengthy periods … on crutches and putting extra strain on my left knee … 22 March 2018 … had a left knee arthroscopic … meniscus repair and chondroplasty …" (ARD 2- 5).

9. The document titled "Schedule of Surgeries" (ARD 7) is noted, including the dates of the surgical procedures in relation to the right knee; 16 October 2010, 26 February 2013, 20 May 2014, 26 April 2016 and 1 June 2017.

Dr Sherif Rizkallah

10. He began treating the applicant's right knee in September 2010 (ARD 97). He reported to the Insurer on 13 September 2010 and noted the applicant was demonstrating an antalgic gait. I take it this means he was then walking with an altered gait so as to avoid pain in his right knee. Dr Rizkallah also noted a limp in his 29 November 2010 report (ARD 101). His examination on 7 February 2011 also demonstrated an antalgic gait (ARD 102). On 30 March 2011, clinical examination again "demonstrates a severe limp" (ARD 103). On 13 August 2012, he again noted the applicant was "still having significant bother … to his right knee with constant pain, swelling and dysfunction … relies constantly on a walking stick for mobility…" (ARD 109).

11. On 22 April 2013, after the right TKR, Dr Rizkallah reported to the Insurer that the applicant "walks with a slight limp using a walking stick for security" (ARD 119). A "slight limp" was also reported to the Insurer on 5 September 2013 (ARD 112).

12. On 25 June 2014, Dr Rizkallah reported that following the revision right TKR, the applicant "walks almost normally with his knee in neutral alignment" (ARD 130). But by 29 May 2015, Dr Rizkallah had to report that "he unfortunately continues to have significant pain and disability … to his right knee …" (ARD 147). Then, following the revision right knee TKR on 26 April 2016, Dr Rizkallah reported (16 May 2016) that the applicant demonstrated "normal gait" (ARD 168). He also noted (8 June 2016) the applicant walking "… normally full weight bearing" (ARD 170). But he later (21 September 2016) noted the applicant complaining of recurrent swelling and clicking and minor discomfort in his right knee and "mobilising full weight bearing without support … has slight difficulty transferring …" (ARD 177).

13. Following further surgery to the right knee on 1 June 2017, Dr Rizkallah reported to the Insurer, on 15 June 2017, that the applicant " …has concerns in relation to the ***left knee*** which he injured back in 2015 compensating for his right knee and surgery …" (ARD 190). He noted the applicant describing "pain, clicking and swelling, which is not responding to the usual non-operative treatment options". He suggested the applicant undergo left knee arthroscopic meniscectomy and debridement procedure.

Dr S. Raj Sundaraj, Specialist Pain Medicine Physician

14. He saw the applicant for the first time on 28 November 2014, referred by his GP, Dr Virk. The applicant had undergone a right TKR in March of 2014. Dr Sundaraj noted the applicant described the development of low back pain "… and in time, pain in the left knee as well due to greater support required for his ambulation …". He continued to see the applicant on

various occasions up to June 2018, as far as the evidence goes. Dr Sundaraj noted the applicant walked with a limp on 10 March 2015; and that there was "intermittent swelling, colour changes and other signs and symptoms" on 31 March 2015. He diagnosed the applicant as suffering " … neuralgia as a consequence of his injury and subsequent surgery…" (ARD 140). His last report on 1 June 2018 notes the applicant:

> "continues to be troubled with pain in his bilateral lower limbs … in the left lower limb, pain can be severe and troublesome intermittently … troubled with a neuropathic and nociceptive pain … right knee pain is predominantly neuropathic … is using the spinal stimulator implant and this is easing his pain by about 40-50% … seek your approval for this man to undergo our new "scrambler" therapy … a non-invasive outpatient based therapy … attend a minimum of 10 consecutive sessions … to stimulate "non-painful" pain receptors … creates re-wiring or neuroplasticity to the spinal track) …"

Dr Ali Gursel, Hip & Knee Surgeon

15. On 25 February 2019, Dr Virk referred the applicant to Dr Gursel "… for a second opinion about my knees … I had begun to lose confidence in Dr Rizkallah …" (ARD 5).

16. Dr Gursel noted the applicant "walks with a markedly altered gait pattern …" After reviewing inflammatory markers and Gallium scan tests, he wrote to the Insurer, on 25 March 2019, with an "urgent surgery request". He quoted surgeon's fees at $6,000. He also wrote to Dr Virk noting that, following the tests, he had arrived at a diagnosis of advanced arthritis of the left knee. He then wrote:

> "… the first line of management is to deal with his symptomatic left knee to give him a stable platform to recover from … would involve (TKR) …" (ARD 209-210)

17. Dr Gursel wrote to the applicant's solicitor on 15 May 2019 noting that his:

> "observations and on clinical examination … he has an arthritic left knee … as well as the imaging … left knee requires total knee arthroplasty, having exhausted all the non-arthroplasty options available to him … the left knee arthritis has developed as a direct result of his work injury and his altered gait pattern which has been apparent since 2010 … there is no other alternative management or treatment for Mr Taylor's arthritic left knee…" (ARD 212).

Dr Peter Conrad, Surgeon

18. He was engaged by the applicant's solicitor to provide a forensic opinion and wrote six reports – dealing with injuries to both the applicant's upper and lower limbs. He observed:

> "… Mr Taylor has had back problems due to his irregular gait … and has now had a permanent spinal stimulator inserted by Dr Sundaraj. Due to ongoing swelling in the knee and problems with the wound … had a third revision arthroplasty … due to his irregular gait, he has had problems with his left knee and … is waiting for approval for arthroscopy on the left knee … continues to have considerable pain and stiffness in both knees … due to an irregular gait … injured the left knee … will probably eventually need a knee replacement … in the future …" (ARD 52-53).

19. He also made it clear he believed there was no pre-existing injury, condition or abnormality, including disease, in the left knee (ARD 56). He responded to the comment by Dr Machart, orthopaedic surgeon engaged to provide forensic opinion for the respondent, that "the clinical picture was complicated by pain behaviour" with this:

> "I find that this is an absurd statement for an independent examiner to make … Mr Taylor is a very unfortunate person who has had 5 major surgeries to his right knee as

well as surgery to his left shoulder … to accuse him of pain behaviour is absolutely ludicrous" (ARD 60).

20. Dr Conrad went on to say that he supported the recommendations by Dr Rizkallah that Mr Taylor should have arthroscopic surgery to his left knee. That did occur and the Insurer ultimately paid voluntarily.

21. Dr Conrad reported again on 14 May 2019 reiterating, relevantly, that "due to irregular gait … has had problems with the left knee … Dr Gursel has recommended … left TKR … which should be done as soon as possible …" (ARD 65-66).

22. On 9 July 2019, Dr Conrad dealt with the question of whether the proposed left knee surgery is "reasonable and necessary and causally related to his right knee injury…". He observed:

> "… due to irregular gait … has favoured the right knee and over-used … (and)… injuring the left knee … totally agree with Dr Gursel that …(TKR) … now necessary due to … extreme pain and restriction of movement with crepitation indicative of advanced arthritis … left knee condition is causally related to the accident of 14 April 2010 in which he injured his right knee … on the basis of favouring the right knee and putting extra pressure on the left knee…"

23. Dr Conrad also agreed with Dr Gursel's opinion that "the left knee arthritis has developed as a direct result of his work injury and his altered gait pattern which has been apparent since 2010 … no other alternative management of treatment of Mr Taylor's arthritic left knee".

24. Dr Conrad notes that Dr Machart opined that the symptoms in the applicant's left knee were "concordant with osteoarthritis". Dr Conrad then confirmed that "whilst undoubtedly Mr Taylor does have osteoarthritis in the left knee, this has been mainly brought on and accelerated by the maldistribution of weight due to gait irregularity favouring his right knee and therefore has a direct nexus to the accident of 14 April 2010".

Dr Frank Machart, Orthopedic Surgeon

25. In his 3 May 2019 report, after recounting the history and his views – with respect to the applicant's various injuries – Dr Machart noted that the applicant had then outlined:

> "... that his left knee symptoms developed as a result of "overuse" and limping following right knee injury in 2010, and that his symptoms and walking capacity …now described to be at 15-20 minutes had not changed much since the time of the injury …" (ARD 52).

26. He then opined that the left knee:

> "…is affected by osteoarthritis … did not see validity in the generic suggestion that this was affected by "overuse". Reasoning is that consequential injury on the opposite limb is not supported by medical literature. Overuse was not confirmed. The activity level diminished substantially after the right knee injury, limiting his walking capacity to 15 to 20 minutes, spending less time on his feet than he would have been otherwise. This diminished use of the uninjured left knee, not exceeded by altered weight transfer subject to the right knee injury … left knee is affected by osteoarthritis to the same extent as would have [sic] irrespective of the injury to the right knee …" (ARD 54).

27. Dr Machart also assessed the whole person impairment (WPI) of the right and left knees, and found a 3% left knee WPI – with 0% of that "as a result of injury" – compared to a finding of 30% WPI with respect to the right knee – half of which he was prepared to accept "as a result of injury" (ARD 55).

28. In his 3 June 2019 report, Dr Machart reiterated his earlier view and stated that "the left knee was affected by osteoarthritis … no evidence of "overuse" … complication through pain behaviour …" Then he added the following regarding the proposed left knee surgery:

> "… in relation to Dr Conrad's … recommendation for left knee replacement … I assessed Mr Taylor is suffering from constitutional osteoarthritis … explained why I did not believe this to be a consequential injury … no evidence of "overuse". If anything, there was underuse … left knee could be treated for osteoarthritis …do not believe … this is consequential upon the injury to the right knee … funding for this operation should not be part of the index injury on 14 April 2010 …" (ARD 67).

SUBMISSIONS

For the Applicant

29. The accepted right knee injury is a serious injury. It has required at least five major operations. It has caused the applicant substantial pain and resulted in him requiring large amounts of pharmaceutical assistance to deal with that pain.

30. Because this is a consequential injury case, the first issue should be decided on common law causation principles noted in cases such as *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452: 10 NSWCCR 796 (*Kooragang*) – including by applying common sense to the causation analysis. The applicant has had a number of major operations, after which he was substantially immobilized for significant periods, sometimes with a walking stick, with substantial pain. So it is logical that he developed an altered gait and relied more on his left leg. This type of injury is well-known in cases in this commission.

31. The applicant's evidence is not in dispute. Reference was made to, and I have noted, paragraphs 11 -12, 14, 16 – 18, 22, 26 & 34 of his statement as grounding and supporting the argument that the altered gait included worsening limping, resulting in the injury to the left knee. A summary of that content appears in the treatment of the applicant's evidence above.

32. Reference was made to WorkCover medical certificates, between 26 May 2011 and 27 November 2012 (Reply 420 - 438). They do not refer to the left leg or knee, rather to the right knee injury, with lower back pain secondary to limping. But they do show significant limping as a result of the right knee injury. The certificates of 8 January 2013 and 2 June 2014 refer to the right "knee injury, lower back pain secondary to limping, left knee pain…lt. knee pain due to compensation…(Reply 440 & 453)".

33. The applicants GP's records do not record complaints, but do record strong medication being regularly prescribed (Reply 298 – 349). This is relevant because the reports by Dr Machart, "makes light of" the applicant's complaints of pain - using the term "pain behaviour" with reference to his presentation. Dr Machart is saying the applicant is "malingering". This opinion is incorrect. It also descends to being adversarial.

34. Dr Machart's various use of the term "overuse" (of the left leg or knee) is an attempt to show that he does not believe the applicant's claim, and seeks to belittle it. This is similarly the case with respect to Dr Machart describing the right knee injury on 14 April 2010 as "nebulous" (ARD 71). The right knee injury was clear and it has been admitted. This is a further example of the adversarial nature of Dr Machart's opinion.

35. Mr Tanner then summarised the forensic reports of Dr Conrad. That summary is included in the summary of Dr Conrad's evidence above and does not need to be repeated here. As to the nature of the injury, Dr Conrad has opined that the applicant has an arthritic left knee – and that "the left knee arthritis has developed as a direct result of his work injury and his altered gait pattern…" (ARD 73). Dr Gursel had earlier said the same thing (ARD 212).

36. Dr Rizkallah's material, including the relevant parts, was referred to (ARD 97 – 123). I have taken this material into account when earlier dealing with this doctor's evidence.

37. As to the second issue, there is no real doubt that the proposed surgery is reasonably necessary. Drs Gursel, Rizkallah and Conrad support it and say why it is needed. Dr Machart does not support it. But he does not give reasons other than those relating to the first issue.

38. The respondent has already voluntarily paid for the left knee arthroscopic medial and lateral meniscus repair and chondroplasty surgery, conducted by Dr Rizkallah, on 22 March 2018.

For the Respondent

39. As to the first issue, the opinion of Dr Machart is correct. It makes sense given that "overuse was not confirmed", and also because of the diminution of activity level after the right knee injury. The applicant's walking capacity was then limited. He was spending less time on his feet. Dr Machart also observed that the left knee was affected by osteoarthritis to the same extent as would have been the case irrespective of the right knee injury.

40. As to the second issue, there have been various other surgical procedures, all of which have been ineffective. This strongly suggests the same thing will happen with this proposed procedure. It is major surgery that is unlikely to benefit the applicant. Also, there is been no exhaustion of alternatives. While it was accepted that Dr Machart did not expressly deal with this issue, including by identifying what alternatives may exist, it is up to the applicant to go through these alternatives as part of his case and this had not been done.

FINDINGS AND REASONS

Issue 1: Has there been a consequential injury to the applicant's left knee as a result of the accepted injury to his right knee?

41. The applicant submits I should find the opinion of Dr Machart "adversarial". There is a basis for this; particularly in the reports of Dr Peter Conrad (e.g. ARD 60) - who stated "with the greatest respect to Dr Machart… absurd … for an independent examiner to say …the clinical picture was complicated by pain behaviour …", in the face of the applicant having had five major surgeries to his right knee. It is not totally clear what Dr Machart means by "pain behaviour". However, if he is inferring that he believes the applicant's complaints of pain were out of proportion to what ought to have been the case, I do not accept his opinion.

42. I do not need to make a finding about whether his opinion is adversarial. It is sufficient to find, and I do, that his opinion about "pain behaviour" is most unpersuasive, and that I prefer Dr Conrad's opinion (the complaints are not out of proportion to what they should be).

43. The applicant's treating doctors also speak well of his motivation, cooperation during examination and consistency. Also, Dr Anderson found his "presentation was completely consistent … came across as a pleasant and decent man … is very disappointed at the extensive development of his overall clinical circumstances" (ARD 44). This reflects my view of the applicant after considering the whole of the evidence. I accept his evidence unreservedly. I also accept the evidence of his treating doctors (as set out in paras 10 – 17 above) particularly with respect to his presentation and the contemporaneous recording of altered gait and limping. There is essential consistency in the evidence from the applicant and the other doctors whose evidence has been dealt with above. Dr Machart's evidence is not consistent with that body of evidence and such is a further reason for not accepting it over Dr Conrad's evidence.

44. Dr Conrad then addressed Dr Machart's view that there was no injury to the left knee; and that the applicant developed pain in it "concordant with osteoarthritis". Dr Conrad noted there was "certainly no evidence of osteoarthritis in the left knee prior to this accident" (ARD 60).

However, whether or not there was osteoarthritis in the left knee prior to the 14 April 2010 injury, there is no evidence of there being any symptom or any prior problem in the left knee before the injury to the right knee on 14 April 2010. This is a factor in favour of the claim that there is a causal relationship – in the *Kooragang* sense - between right knee and the left knee injury. Dr Virk has certified, from 26 May 2011, that the applicant was limping and that such was producing lower back pain. Dr Virk also certified on 8 January 2013 and 2 June 2014 that he was having left knee pain "due to compensation" in the context of the right knee injury and lower back pain secondary to limping (see paragraph 32 above).

45. The respondent has agreed that the test for the purposes of identifying the consequential injury to the left knee was that laid down in cases such as *Kooragang*: that is, a simple factual question as to whether the second injury resulted from the earlier injury (*Bennett v Qantas Airways Ltd* [2019] NSWWCCPD 23 at [56]). I am more than comfortably satisfied the applicant's case has shown this, and believe it a strong case in this regard.

46. Dr Machart reported that " …Mr Taylor outlined today that left knee symptoms developed as a result of 'overuse' and limping following right knee injury in 2010 …(Reply 52) … overuse was not confirmed" (Reply 54). It is not clear why Dr Machart has utilised inverted commas around this word (at Reply 52 and other occasions). The first thing to consider in this regard is that the text and context of "overuse" (at Reply 52) is that he quoting what the applicant said to him verbatim. But I am not prepared to find that was the case. The applicant does not relevantly use that term in his evidence, nor is it relevantly used by other doctors – except in relation to issues relating to his upper limbs.

47. It is also odd that Dr Machart has put inverted commas around the word "overuse" (Reply 52), yet not do the same for the word "limping" appearing in the same clause. This matters because his ultimate conclusion appears to be significantly based on his belief that "overuse was not confirmed". While it is, again, not totally clear what he means by this, an inference can be drawn, and I do, that it has not been confirmed that the applicant was required to use his leg in any excessive way after his right knee injury – and he was using it less because his ability to ambulate was more restricted. However, this is a shallow and one-dimensional way to approach the issue. It also tends to reframe the way the applicant has framed his case – which was on the basis of limping and altered gait and favouring his right leg and knee.

48. But Dr Machart's evidence does go deeper in this regard to opine that "this diminished use of the uninjured left knee, not exceeded by altered weight transfer subject to the right knee injury…"(Reply 54). Again, it is not *totally* clear what is meant. But I do infer that it represents an attempt to opine that there was no altered weight transfer from the right knee to the left knee. If that is what is meant, I reject that evidence too. It is not only unsupported by any reasoning or basis, but is palpably inconsistent with clear and consistent histories from the applicant's treating doctors of limping and altered gait (see paragraphs 10 – 17 above).

49. Dr Machart also stated he "did not see validity in the generic suggestion that this (osteoarthritis) was affected by "overuse". Reasoning is that consequential injury on the opposite limb is not supported by medical literature…" (Reply 54). I reject this opinion as well. While this commission is not bound by the rules of evidence, it is still required to draw its conclusions from material that is satisfactory, in the probative sense, to ensure that conclusions reached by it are not seen to be capricious, arbitrary or without foundational material (*OneSteel Reinforcing Pty Ltd v Sutton* [2012] NSWCA 282 at [2] per Allsop P). Dr Machart has only provided a bare conclusion. There is no supporting literature, authority or other evidence attached, referenced or mentioned. **Drs GURSEL SUNDA? RIZ CON?**

50. In the result, I am again more than comfortably persuaded that the evidence of Drs Conrad (see paras 18 and 21 – 24 above), Rizkallah (see para 13 above) and Gursel (see para 17 above) are to be preferred over that of Dr Machart on this issue. And I find there has been a consequential injury to the applicant's left knee as a result of the injury to his right knee on 14 April 2010. The nature of that injury is osteoarthritis.

Issue 2: Is the proposed surgery reasonably necessary?

51. The submission for the respondent in this respect was properly and forcefully made. There is some common sense about the proposition that the ineffectiveness of multiple previous surgeries makes it unlikely that the present proposal will benefit the applicant. However, the difficulty with it is that there is no medical evidence to support it. Not even Dr Machart raises this issue. To the extent that one may infer that he did deal with the question, he *may* be implying that he has no difficulty with the reasonable necessity of a left knee TKR. He agreed "that the left knee could be treated for osteoarthritis", but then immediately added "I do not believe … this is consequential upon the injury to the right knee". He made the first of those comments in the context of "Dr Conrad's recommendation for left knee replacement".

52. However, it is not necessary to draw any such inference. It is sufficient to find, and I do, that if any evidence of Dr Machart on this issue does exist, it is far outweighed by the opinions of Drs Conrad and Gursel. They believe the proposed surgery is reasonably necessary (see paragraphs16 -17 and 22 - 24 above). The medical evidence on the issue is really all one way. That is not to suggest I do not take into account the submission for the respondent referred to in para 51above. I do. But the evidence supporting it is also outweighed by the medical evidence for the applicant. So, my finding in this respect is made most comfortably. In making the finding, I have considered and taken into account the principles discussed in *Diab v NRMA Ltd* [2014] NSWWCCPD, where Roche DP noted:

> "… it is not simply a matter of asking … is it better … the worker have the treatment or not … worker … does not have to establish treatment is "reasonable and necessary" … a significantly more demanding test … different treatments may qualify as "reasonably necessary" and worker only has to establish … the treatment claimed is one of those treatments … [86] "

53. Roche DP also stated that the treatment in question must be "a reasonable necessity" having regard to all of the relevant factors, as set out in *Rose*, according to the criteria of reasonableness, including "any available alternative treatment" and "cost" factors.

54. I note that the s 78 notice denies liability for the alternative treatment on the basis that it was not "reasonable and necessary". As noted above, this is too demanding a test. But that is not dispositive here. The argument for the respondent has been analysed on the merits taking all evidence into account. In particular, there is clear evidence from at least Dr Gursel that he has recommended this surgery in the context of and after "having exhausted all the non-arthroplasty options available" (ARD 212 and see paragraph 17 above). When he first considered the applicant's case, he noted the right TKR, followed by two further revisions, synovectomy and "to compound all this… Has a spinal nerve stimulated which unfortunately has not really helped the symptoms…". He then made arrangements for various tests including gallium, bone and MRI scans (ARD 208). Thereafter, he noted that the scans showed the applicant had "advanced arthritis of his left knee and requires a total knee replacement… pain and stiffness… patella… scarring his… ligament and dropping the position of the patella quite close to the tibial component..". I am satisfied that Dr Gursel has properly considered the reasonable necessity of a left TKR.

55. Otherwise, there are no other options referred to, let alone posited, in the respondent's medical evidence. This also deals with the respondent's argument (no exhaustion of alternatives) with respect to the second issue.

SUMMARY

56. I find there has been a consequential injury to the applicant's left knee as a result of the injury to his right knee on 14 April 2010. The nature of that injury is osteoarthritis.

57. I also find that the left TKR surgery proposed by Dr Gursel is reasonably necessary within the meaning of s 60 of the 1987 act.