WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3950/19**
Applicant: **Brett Chevor**
Respondent: **Sterihealth Services Pty Limited**
Date of Determination: **5 November 2019**
Citation: **[2019] NSWWCC 356**

The Commission determines:

1. The respondent will pay the costs of and associated with the surgery recommended by Dr Coffey in his reports of 29 November 2018.

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

John Wynyard
Arbitrator

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

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Brett Chevor, the applicant, was injured on 25 January 2015 when, in the course of his work as an autoclave worker, a bag of blood broke and he slipped on it, injuring his left knee. He has undergone intensive treatment for that injury and it is the unanimous opinion of those medical specialists who have considered the possibility that he will eventually come to a total knee replacement. He was born in 1977 and the opinion is that he is too young at present to have a total knee replacement. He has already undergone two bouts of surgery on his knee and now seeks to undergo a further procedure which has been resisted by the respondent as being not reasonably necessary.

2. Several s 74 notices have been issued and the Application to Resolve a Dispute and Reply have been duly lodged.

ISSUES FOR DETERMINATION

3. The parties agree that the following issue remains in dispute:

    (a) Is the proposed surgery reasonably necessary.

PROCEDURE BEFORE THE COMMISSION

4. The matter was heard on 3 October 2019. Mr Bill Nicholson of counsel appeared for the applicant instructed by Messrs Brydens Lawyers and Ms Sarah Warren appeared for the respondent instructed by Messrs Hall & Wilcox. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Documentary Evidence

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

    (a) The ARD and attached documents;
    (b) Reply and attached documents;
    (c) Application to Admit Late Documents (ALD) dated 19 September 2019.

Oral Evidence

6. No application was made in respect of oral evidence.

FINDINGS AND REASONS

7. Mr Chevor relied on the opinion of Dr Simon Coffey, Orthopaedic Surgeon, who recommended a left knee patellofemoral replacement arthroplasty and removal of screws in a report of 29 November 2018.

8. Dr Coffey is the third surgeon to be involved in the surgical management of Mr Chevor's case.

9. Mr Chevor was first referred to Professor Warwick Bruce by his then GP, Dr Peter Kenny at the Dellwood Medical Centre. Professor Bruce first reported on 17 March 2015 and took a consistent history of the circumstances of the injury. He noted that an MRI scan of 4 February 2015 showed patellofemoral mall tracking, dysplasia, patella alta and lateral patellar tilt, and that there was Grade 4 lateral wear of the patella. A tear of the lateral meniscus was also identified.

10. Professor Bruce diagnosed that the injury had made symptomatic Mr Chevor's asymptomatic patellofemoral arthritis, which was due to malltracking. Professor Bruce recommended physiotherapy, but by 14 April 2015 Mr Chevor reported that it was causing him pain. A steroid injection was proposed.

11. Professor Bruce reported on 4 May 2015 that the injection had helped for a few hours only. He recommended "a lot" of physiotherapy.

12. By 6 July 2015 Professor Bruce reported that Mr Chevor's condition had plateaued. He then recommended an arthroscopy and chondroplasty. Professor Bruce noted that the surgery would cause wasting, and that Mr Chevor would have to work "very diligently" post-operatively.

13. In his operation report of 5 August 2015 Professor Bruce reported that a chondroplasty had been performed and that Mr Chevor needed to undergo a rehabilitation regime post-operatively, aimed mainly at patellofemoral rehabilitation.

14. On 14 September 2015 Professor Bruce reported to Dr Kenny that when he first saw Mr Chevor prior to the operation, Mr Chevor weighed 95 kg. On 14 September 2015 he weighed about 110 kg. Professor Bruce said that he had told Mr Chevor to lose weight, "so this is a disaster."

15. In the meantime, the respondent paid for physiotherapy and hydrotherapy in an effort to rehabilitate Mr Chevor. It was reported that Mr Chevor was not participating in the programmes set out for him with any enthusiasm and indeed his absence was noted in various reports.

16. On 24 November 2015 Professor Bruce thought that Mr Chevor would never reach his pre-injury status.

17. On 3 December 2012 Dr Simon Coffey, Orthopaedic Surgeon, reported to Dr Merchant, Mr Chevor's family doctor in Springwood. Dr Coffey took a consistent history, including the surgery with Professor Bruce. Dr Coffey noted that Mr Chevor reported no improvement in his symptoms and a steady deterioration in function following that surgery. Dr Coffey also noted that associated with those symptoms was ongoing issues relating to depression, for which Mr Chevor was under the care of a psychologist and a psychiatrist.

18. Dr Coffey observed that Mr Chevor had the “very difficult to manage problem of advanced patellofemoral osteoarthritis in a 38-year-old man with a physically demanding role.”[1] He noted that there was no consensus regarding either surgical or non-surgical management, and that nonoperative measures had been exhausted. Under those circumstances, Dr Coffey thought that it would be reasonable to consider tibial tuberosity osteotomy with lateral facetectomy of the patella, although he thought it was unlikely to return Mr Chevor to normal function. It would however enable moderate activities of daily living without severe discomfort, Dr Coffey thought.

[1] ARD 31

19. The respondent retained the services of Dr Tim Anderson, Occupational Physician, who first reported on 23 December 2015. Dr Anderson took a consistent history of Mr Chevor's injury and treatment up to that time. He noted that Mr Chevor had initially been under the care of the company GP, but that he had changed to his own family doctor by the time of Dr Anderson's report. Dr Anderson noted that Mr Chevor and undergone acupuncture, electrotherapy, massage, hydrotherapy and the use of an exercise bike. None of those modalities was successful, although Dr Anderson doubted Mr Chevor's assertion that hydrotherapy made his knee worse.

20. Dr Anderson confined his diagnosis to "a hurt knee", saying that he had not seen the operation report by Professor Bruce. He noted that Mr Chevor was then under the care of Dr Simon Coffey. Dr Anderson said:[2]

> "Mr Chevor was quite a friendly young man. Unfortunately, he is very convinced of his own views about his condition. He seems to have a very strong opinion that if he has further surgery, his left knee condition will be fully resolved. He is also very resistant to pursuing any kind of realistic physiotherapy exercising, particularly working his quads..... With this type of attitude, he is certainly not heading for a successful outcome."

21. He thought that Dr Coffey was not overly keen on further surgery, and said that surgery might ultimately be needed but should not go ahead until Mr Chevor was in a much better state to achieve the best possible outcome. That meant, Dr Anderson said, Mr Chevor had to lose his excess weight and start working on his quadriceps. Dr Anderson thought that Mr Chevor would be "extremely resistant" to that suggestion and would still wish the surgery to proceed. Dr Anderson said that he was very concerned that a surgical procedure would have "disastrous results."

22. Dr Anderson noted that Mr Chevor was back at work doing a driving job, although he expressed concerns that the vehicle was a manual truck. Dr Anderson conceded that the prognosis for the left knee was "not all that good" and that in long-term he anticipated further deterioration with increasing degenerative change which would ultimately come to some form of knee joint replacement. Dr Anderson said that such should be "held off for several decades if he can tolerate it."

23. On 2 June 2016 Mr Chevor consulted Dr Brett Fritsch, Knee Surgeon, on the referral from Dr Merchant. Dr Fritsch took a history of Mr Chevor's management to that point. He said he was not surprised that the earlier surgery did not give any benefit, as the mechanics of Mr Chevor's knee simply overpowered any benefit that might have been obtained. Dr Fritsch recommended a lateral release of the tight lateral retinaculum structures, and a tibial tubercle osteotomy. He said:[3]

> "... a reasonable expectation of improvement is that he is a lot better than he is now but not normal. The amount of cartilage loss that is present makes it impossible for us to give him a normal knee and he'll still have a reduced level of activity as compared to an age-matched normal knee. Nonetheless I think it's his only option of any significant improvement in his quality of life."

24. On 16 June 2016 the proposed surgery was carried out at Nepean Hospital by Dr Fritsch. Dr Fritsch reported on 3 November 2016, noting that Mr Chevor was back at work and saying that he was always happy when patients were so keen to get back to work. Dr Fritsch sounded a word of warning however, as he had been told by Dr Merchant that Mr Chevor was doing both desk work and forklift driving. Dr Fritsch cautioned against the forklift work, saying that if Mr Chevor became too active too

[2] Reply 42
[3] ARD 35

quickly it may impede the healing process. It was critical that Mr Chevor continued to wear his knee brace, which would make it impossible for Mr Chevor to even sit on a forklift, let alone operate one, as the brace would lock his knee in extension.

25. On 20 July 2017 Mr Chevor was seen again by Dr Coffey, whom he had not seen since December 2015. Dr Coffey reported that neither of the previous surgical interventions were successful and that Mr Chevor continued to have moderate peri-articular left knee pain. He had been in the care of the Western Sydney Pain Management Centre and had been seeing a psychologist and psychiatrist Dr Malik at St John of God.

26. Dr Coffey said that Mr Chevor had no significant symptoms in the left knee prior to his injury and that he was now significantly disabled by his patellofemoral arthritis as a significant result of the injury. Dr Coffey recommended that a further MRI scan be taken and that Mr Chevor be considered for a patellofemoral knee joint arthroplasty. The MRI scan was performed on 24 July 2017.

27. A claim for the cost of surgery was duly made, and on 20 February 2018 a s 74 notice issued, denying liability. In the meantime, Mr Chevor remained in the care of the pain management specialists, although he said in his statement that he stopped seeing Dr Boesel at the Western Sydney Pain Centre as he could not afford further treatment. The last report lodged by Dr Boesel was dated 15 November 2017.

28. The insurer obtained an opinion on 28 November 2017 from Dr Michael Giummarra at the Nepean Private Sports Specialist Centre. Dr Giummarra thought that, given the treatment history, a total knee replacement was not in Mr Chevor's best interest, bearing in mind his age and the fact that the longevity of such an arthroplasty is limited. Platelet therapy was discussed in order to deal with his knee inflammation and pain.

29. Dr Graeme Mendelsohn, General Surgeon, reported as medico-legal referee for the applicant on 25 June 2018. He reported that Mr Chevor continued to work for the respondent after recovering from the arthroscopy with Professor Bruce. He left however about six months following the injury he was given light duties beyond his capacity. Mr Chevor tried other jobs such as driving which he found difficult if the vehicles were not automatic, and then he obtained work as a supervisor in a scaffolding company which involved office and administrative work. Dr Mendelsohn reported that Mr Chevor then came to his second bout of surgery with Dr Fritsch in 2016.

30. Mr Chevor was off work for about two months following that procedure and he told Dr Mendelsohn that he had extensive physiotherapy and a lot of home-based exercise. He then returned to the scaffolding company for the next six months or so. He apparently left that job and tried to return to driving five months prior to the consultation with Dr Mendelsohn but, due to problems with that occupation, had found work at Katoomba Hospital, working in the kitchen. Dr Mendelsohn recorded that Mr Chevor did not feel that the surgery had helped him, that his symptoms continued and that he continue to need extensive analgesia.

31. Dr Mendelsohn's opinion confirmed those of the other specialists to that point, that is to say the injury had resulted in an aggravation of patella degenerative condition and Dr Mendelsohn thought that there was an injury of the tibial plateau with cartilage damage resulting in the need for a tibial osteotomy.

32. When asked about the treatment that had been given, Dr Mendelsohn agreed that the surgical procedures thus far had been appropriate and reasonably necessary. He thought there would be a continuing degeneration of the knee joint in the future and the supervention of increasing osteoarthritis. Dr Mendelsohn, too, thought it was possible a total knee reconstruction would be necessary in the future. He said:

> "This is certainly not required at this stage, however. He is likely to have continued symptoms, however, with pain and weakness in the left knee was altered gait, continued stress and pain in the other joints of his lower limbs. He is likely to require a continued gentle exercise programme to help maintain mobility."

33. Mr Chevor was referred back to Dr Coffey, who reported on 20 July 2017. He noted that Mr Chevor had been under the care of the Western Sydney Pain Management Centre as well as a psychologist and psychiatrist. He carried out an examination and considered the recent imaging, which showed evidence of the previous tibial tuberosity osteotomy, with two screws in situ.

34. Dr Coffey again noted that Mr Chevor had a difficult problem of residual patellofemoral knee pain due to post-osteoarthritis of the patellofemoral joint. Dr Coffey repeated his earlier opinion that Mr Chevor did not have any significant symptoms in the left knee prior to the subject injury, and that he is now significantly disabled by that injury, which was a "significant contributor" to the onset of symptoms. On that basis, Dr Coffey repeated his recommendation for a patellofemoral knee joint arthroplasty, pending a new MRI scan.

35. The respondent sought a further opinion from Dr Anderson, who reported on 17 September 2018. Dr Anderson took a consistent history of Mr Chevor's management since he last saw him in December 2015.

36. Dr Anderson noted that Mr Chevor was still working at Katoomba Hospital, mostly as a kitchen assistant, working full hours. He noted Mr Chevor's complaints of pain in the left knee and his restrictions in movement because of his condition. Dr Anderson thought that Mr Chevor presented in a similar fashion to when he was last seen in 2015. He noted that Mr Chevor remained overweight, Dr Anderson confirmed that Mr Chevor's prognosis was not good and that clinical management in the future was going to be "extremely difficult" to give him any kind of reasonable result. Dr Anderson repeated that weight loss was absolutely vital, although he conceded its purpose could only be to reduce the further deterioration which was "an inevitable feature" of his condition.

37. On 29 November 2018 Dr Coffey reviewed Mr Chevor, having not seen him since July 2017. Dr Coffey said that Mr Chevor's picture was complicated by his workers compensation issues, his weight and his age. He said:

> "It is pleasing on the other hand to see that he has come off narcotic pain management which certainly improves his general outlook and prognosis."

38. Dr Coffey continued to recommend a patellofemoral replacement arthroplasty. He said that "at the end of the day" it was a judgement call based upon Mr Chevor's symptoms.

39. In his final report of 2 July 2019, Dr Coffey summed up Mr Chevor's injury by saying that it brought to light previously asymptomatic osteoarthritis of the patellofemoral joint.

40. On 13 September 2019, Dr Anderson reported again to the respondent. He said in answer to a question as to whether the proposed surgery would benefit Mr Chevor:

> "It is always possible that Mr Chevor may experience improvement from such a procedure. (If this ever goes ahead, I would wish all success that it should be to his benefit.) Nevertheless, if his previous track record of surgery is anything to go by, I would be very concerned. Similarly, if his previous track record of almost complete avoidance of doing anything to try to improve his condition is anything to go by, I would suggest that these concerns would be further magnified. With the greatest respect to Mr Chevor, my impression, having seen him on two occasions, was that he had his own quite rigid views of his circumstances and for reasons which I cannot understand, appears to be most reluctant to effectively exercise the quadriceps and lose his excess weight."

41. When asked if a weight loss program would be a viable alternative treatment, Dr Anderson observed that Mr Chevor's weight gain had been in existence for a long time, and that his condition had deteriorated to the extent that he required specific pain management. Dr Anderson conceded that there had been no success in obtaining any realistic weight reduction.

42. At page 3 of his report of 13 September 2019, Dr Anderson was asked whether the potential of a number of alternative treatments could achieve the same degree of symptomatic or functional improvement in the left knee as the proposed surgery. Dr Anderson said:

> “With the greatest respect, I do not think anybody could possibly make any such claim. Nevertheless, I would doubt if physiotherapy or platelet therapy would make any significant difference. Synvisc injections might and theoretically probably would, although the extent to which this might happen is just unknown. Hydrotherapy as such, probably would not make much difference and is unnecessarily expensive for what it is. Nevertheless, his own self-managed exercise regime in the water and also on land would certainly get my support and this is largely what I had hoped would have been happening virtually since the time of the injury. The main issue here is to make sure that he knows what to do, how to do it and that he actually gets on and does enough of it. Therefore, the most accurate answer I could give to this question is that I would champion his own aquatics (an ordinary heated pool would do fine) and home-based exercise regime. If this ever gets up and running, it is very important to make sure that his activities are accurately monitored so that we can observe any changes.”

43. At all times he has been under the care of his general practitioner, Dr Merchant, whose clinical notes were lodged. It is convenient to refer to an entry in those notes, as it was relied on by the respondent.

44. I was referred to the clinical notes of Dr Merchant. On 20 November 2014 an entry read:

> "P H - anxiety
> partner – Jenille – recent twins"
> …..
> “Chronic generalised anxiety disorder”

SUBMISSIONS

45. For the respondent Ms Warren submitted that Mr Chevor had not established that the proposed surgery would be of any benefit to him. She referred to the opinions of Professor Bruce and Dr Anderson that the attitude demonstrated by Mr Chevor was coloured by his psychiatric state, and his failure to follow the rehabilitation that had been recommended. She referred to the comment by Professor Bruce that Mr Chevor's weight gain was "disastrous", and the observation by Dr Anderson in 2015 that he was resistant to pursuing realistic rehabilitation. Ms Warren referred to the opinion expressed by Mr Chevor to Dr Anderson that further surgery would fully resolve his knee condition.

46. She referred to comments by Dr Malik, the psychiatrist who treated Mr Chevor. In a report of 5 June 2017 that Mr Chevor's mental state would not improve until he had had his knee pain relieved, perhaps by a total knee replacement.[4]

47. Ms Warren further submitted that I would not be convinced by Dr Coffey's opinion because he had not considered further alternative grounds for ameliorating Mr Chevor's condition such as his losing weight or the strengthening of his quadriceps. Ms Warren referred to the reports of Dr Boesel from the Western Sydney Pain Centre, submitting that at that stage Mr Chevor was suffering from severe depression, although she conceded that Dr Boesel in his report of 30 August 2017 supported further surgery as being the only path to further functional gains.

48. Mr Nicholson referred to the well-known case of *Diab v NRMA Ltd*[5], submitting that the evidence established that Mr Chevor had exhausted all alternative forms of treatment and that, although criticism was made of his attitude, nonetheless the proposed surgery was the only avenue that held any potential for alleviating his condition to some extent before, when the time was right, he had to come to a total knee replacement. He said the respondent doctors were expecting a perfect patient, rather than just an ordinary person who was trying to cope with his injuries. He emphasised the fact that before the accident Mr Chevor had no weight problems at all.

DISCUSSION

49. Section 60 of the 1987 Act provides relevantly:

> "(1) If, as a result of an injury received by a worker, it is reasonably necessary that-
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> (a) any medical or related treatment (other than domestic assistance) Be given, or
>
> (b) any hospital treatment be given, or
>
> (c) ….
>
> (d) ….
>
> the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2).
>
> ……
>
> (5) The jurisdiction of the Commission with respect to a dispute about compensation payable under this section extends to a dispute concerning any proposed treatment or service and the compensation that will be payable under this section in respect of any such proposed treatment or service. Any such dispute may be referred by the Registrar for assessment

[4] at ARD 45

[5] [2014] NSW WCC PD 72 (*Diab)*

by an approved medical specialist under Part 7 (Medical assessment) of Chapter 7 of the 1998 Act."

50. In *Diab* DP Roche set out the principles to be considered when considering s 60. At [76] the learned DP said:

> "The standard test adopted in determining if medical treatment is reasonably necessary as a result of a work injury is that stated by Burke CCJ in *Rose v Health Commission (NSW)* [1986] NSWCC 2; (1986) 2 NSWCCR 32 (*Rose*) where his Honour said, at 48A—C:
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> '3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.
>
> 4. It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgment and good sense, that it is so. That involves the Court in deciding, on the facts as it finds them, that the particular treatment is essential to, should be afforded to, and should not be forborne by, the worker.
>
> 5. In so deciding, the Court will have regard to medical opinion as to the relevance and appropriateness of the particular treatment, any available alternative treatment, the cost factor, the actual or potential effectiveness of the treatment and its place in the usual medical armoury of treatments for the particular condition.'"At [88] DP Roche continued:
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> "88. In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:
>
> (a) the appropriateness of the particular treatment;
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> (b) the availability of alternative treatment, and its potential effectiveness;
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> (c) the cost of the treatment;
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> (d) the actual or potential effectiveness of the treatment, and
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> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.
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> 89. With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts."

51. The diagnosis of Mr Chevor's unfortunate condition is that he suffers from a congenital condition, being as described by Dr Anderson as a "pre-existing mal-tracking condition of the left patella which had deteriorated to such an extent that he had associated degenerative changes. This condition had been quite badly aggravated by the wrenching injury in early 2015."

52. It was common ground that this condition was asymptomatic prior to the subject injury.

53. The cautious approach by the insurer is understandable. Two prior surgical procedures to the knee have failed, and the best light in which the current recommendation can be shown is that it is a stop-gap attempt to delay what all specialists agree will be inevitably a total knee replacement. It is also common ground that Mr Chevor is too young to contemplate that procedure, as its relatively short longevity makes it an inappropriate procedure at this time in his life.

54. Mention has also been made of an earlier "chronic anxiety state" found in the notes of Dr Merchant, to which I have referred. Although reports of Dr Malik, Mr Chevor's treating psychiatrist were lodged, they were only concerned with a secondary psychiatric state that had arisen as a result of his frustrations with his knee condition. There is no evidence as to what the earlier chronic anxiety state was, and I have a great deal of hesitation in accepting an entry in a busy GPs notes as evidence that there was a relevant psychiatric state that pre-existed the subject injury.[6]

55. I am satisfied that the treatment is appropriate. Whilst it is unfortunate that Mr Chevor has not been able to lose the weight that was criticised, the determination that he has shown to remain gainfully employed and active demonstrates his resolve to overcome his disability is much as he could. I note Dr Anderson's view that even if Mr Chevor was of an appropriate weight and had done the appropriate quadriceps exercises, the condition of his knee would still have deteriorated.

56. I am also satisfied that Mr Chevor has availed himself of alternative treatment. Again, Mr Chevor's weight gain and his less than optimal enthusiasm for doing quadriceps exercises has been referred to by the respondent as a possible further avenue of treatment.

57. However, Dr Anderson conceded that the deterioration in Mr Chevor's condition since the subject injury had resulted in a pain management course. Dr Anderson said that even if Mr Chevor lost his excess weight, there was still likely to be substantial mechanical stresses and strains on the left knee. It might defer the need to surgical treatment, but Dr Anderson thought that appropriate weight loss and appropriate exercise of the quadriceps would more likely improve the chances of success in the event of future surgery.[7] I am not satisfied that the question of Mr Chevor's weight or of focussed quadriceps exercise are relevant factors.

58. None of the alternative treatments have had any ameliorating effect on Mr Chevor's condition, and Dr Anderson quite realistically noted that physiotherapy, hydrotherapy, platelet therapy or injections would have any meaningful effect.

59. There has been no suggestion that the cost of the surgery is unreasonable, and all specialists are of the one mind that Mr Chevor will eventually have to come to total knee replacement. Looking at Dr Anderson's 2019 report, I am left with the impression that the proposed surgery is, in the end, the only likely treatment that will improve Mr Chevor's situation.

60. As to the actual or potential effectiveness of the proposed surgery, it would appear that one of the approaches Mr Chevor has employed is to convince himself that surgery will completely alleviate his condition. It is common ground that this will never occur, but the legal test, as referred to by DP Roche, does not require a guarantee of total success.

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[6] See *Mason v Demasi* [2009] NSW CA 227

[7] ALD 2

61. In the facts of this particular case a less than ideal result is inevitable, in that the recommended surgery will not, and has not been held out to be, a treatment that will restore Mr Chevor to his pre-injury state. Mr Chevor has an unusual constitutional condition, in that the maltracking in his patella has led to a deteriorating osteoarthritic condition which has been resistant to all forms of treatment, including two bouts of surgery. It may very well be that Mr Chevor has not helped himself in turning a blind eye to the seriousness of his situation. It may be that his enthusiasm to return to inappropriate forms of work did not assist his recovery from the earlier surgical interventions, as noted by Dr Fritsch. However, such a stoic approach to his responsibilities (I note he has four children) does not disentitle him to the relief he seeks. I am satisfied that the operative procedure, has the potential to both delay the eventual total knee replacement, and to ease the symptoms of his condition in the meantime. To cite Burke J, the particular treatment is essential to, should be afforded to, and should not be forborne by, the worker.

62. Accordingly, there will be an award in favour of the applicant.

SUMMARY

63. The respondent will pay the costs of and associated with the surgery recommended by Dr Coffey in his reports of 29 November 2018.