WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2236/20**
Applicant: **Rosemary Ruth Bowering**
Respondent: **Bi-Lo Pty Ltd**
Date of Determination: **3 July 2020**
Citation: **[2020] NSWWCC 220**

The Commission determines:

1. The total right knee replacement surgery proposed by Dr Samuel MacDessi is reasonably necessary as a result of the applicant's injury arising out of or in the course of her employment with the respondent on 8 February 2010.

The Commission orders:

2. The respondent to pay the costs of and incidental to the 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.

Jill Toohey
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 JILL TOOHEY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Rosemary Bowering, was employed by the respondent, Bi-Lo Pty Ltd, as a sales assistant when she injured her right knee on 8 February 2010. Ms Bowering was serving a customer at a checkout when her right foot became caught on a mat she was standing on, and she twisted her right knee.

2. An MRI on 11 March 2010 showed a medial meniscal tear in Ms Bowering's right knee as well as osteoarthritis. On 31 March 2010 she underwent an arthroscopy to repair the tear.

3. The respondent accepted liability for Ms Bowering's injury.

4. Ms Bowering returned to her pre-injury duties in March 2011 and continued in her employment until 2015 when she reduced her hours so she could care for her elderly parents. In 2016 she ceased work altogether to care for her parents. Around the same time, she saw a specialist for review of worsening pain in her right knee. She continued with conservative treatment until early 2019 when she saw a different specialist who recommended she have a total knee replacement. She is yet to undergo surgery.

5. Ms Bowering claims compensation pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act) for the cost of the total knee replacement resulting from the aggravation, acceleration, exacerbation or deterioration of the degenerative condition in her right knee.

6. By notices issued under s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* on 20 November 2019 and 10 March 2020, the respondent denied liability to compensate Ms Bowering. The respondent does not dispute that the proposed surgery is reasonably necessary treatment but maintains that it is not reasonably necessary as a result of Ms Bowering's injury.

ISSUES FOR DETERMINATION

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

    (a) Whether the proposed total right knee replacement is reasonably necessary as a result of Ms Bowering's accepted injury.

PROCEDURE BEFORE THE COMMISSION

8. The parties attended a conciliation/arbitration on 12 June 2020. Mr Stuart Moffet of counsel appeared for Ms Bowering. Mr Tony Baker of counsel appeared for the respondent. 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

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

    (a) Documents attached to the Application to Resolve a Dispute;

(b) Documents attached to the Reply;

(c) Documents attached to an Application to Admit Late Documents lodged by the applicant on 4 June 2020.

Oral evidence

10. There was no oral evidence.

FINDINGS AND REASONS

Ms Bowering's evidence

11. Ms Bowering's evidence is set out in a statement dated 21 April 2020 and a supplementary statement dated 2 June 2020.

12. In her first statement, Ms Bowering says she had no injuries or symptoms in her right knee before 8 February 2010 when she was serving a customer and turned to place an item in a bag; her right foot got stuck to a sticky patch on a mat and she twisted her right knee. She heard a crack and felt immediate pain. The work doctor referred her to Dr Allen Turnbull, orthopaedic surgeon.

13. Dr Turnbull arranged for her to have an MRI which showed a medial meniscal tear. Dr Turnbull performed an arthroscopy on 31 March 2010. Ms Bowering says it did not result in a lot of improvement in her knee and she continued to suffer from pain.

14. Ms Bowering says that, following the surgery, Dr Turnbull told her she would eventually require more extensive surgery such as some form of arthroplasty. She was told to delay further surgery until she could no longer manage the symptoms.

15. Ms Bowering says she resumed her pre-injury duties despite ongoing pain and symptoms. Around 2015, she reduced her hours so she could care for her elderly parents. By 2016, she ceased work altogether to look after her parents. Her father was in a nursing home and her mother was living on her own. She would attend to errands, take her mother to doctors' appointments, spend time with her parents and so on. There was no heavy work involved in caring for them such as lifting or bathing.

16. Ms Bowering says her right knee has been getting gradually worse over the last six years. Around the time she ceased work in 2016, she decided to see a specialist again for review. Dr Molnar recommended she trial non-operative measures to see if the pain settled.

17. Around early 2019, she went back to a specialist for further review. Dr MacDessi recommended she undergo a total knee replacement. She would like to proceed with the surgery.

18. Ms Bowering says her right knee is now at the point where she is in constant pain. She struggles with prolonged standing, walking and climbing stairs, and she cannot kneel, squat or climb. She cannot run or jump and has trouble standing up from a seated position. She has to carry heavy items on her left side and has difficulty with heavy domestic tasks. She takes medication for the pain.

19. In her supplementary statement, Ms Bowering says she underwent rehabilitation including physiotherapy and exercise physiology after the surgery in March 2010. It took almost a year to recover to the point where she was able to return to her pre-injury role. She was under a lot of financial stress and pushed herself to get back to work. She finally trialled a return to her pre-injury role in March 2011. At first she was doing her normal duties but she had to break them up throughout the day and take regular breaks to avoid repetitive tasks or prolonged standing.

20. Ms Bowering says that, even when she resumed full duties, she was still seeing an exercise physiologist who gave her a chart of exercises so she could continue them at home herself. (A copy is attached to her statement). They included push-ups against a wall, lunges while lying down, and exercises with a ball. She continued to do them whenever her knee caused her pain, even after she resumed normal duties. Her knee was usually worst after a long shift at work.

21. Around 2013, her father became quite ill. In 2014 he was worse and he eventually went into a nursing home. She was always busy doing things for her parents in between shifts at work. She never had time for herself. Her knee was still causing her pain, particularly after a long shift at work, but she did not have time to always get it checked. She would just do the exercises, rest and take pain medication when necessary.

22. Around September 2014, she applied for the carer's pension so she could reduce her hours at work and look after her parents. It was also convenient timing because it meant she could take pressure off her knee which was gradually getting worse. She tried to keep working part-time for as long as she could. By 2016 she decided to stop work altogether and become a full time carer. The decision was also because her knee was getting worse and she was struggling to be on her feet for long periods at work. Around the time she stopped work, she had further scans and was referred back to the specialist.

23. Ms Bowering says that, after her injury, the doctors always said she would need a knee replacement when it got to the point where she could not stand the pain, so she pushed on for as long as possible. She has continued to experience knee pain since the injury. It has gradually become worse, she has good and bad days but the bad days have steadily increased. She does not like to complain and has put up with the pain as best she could over the past eight to ten years, and managed her condition with exercises, rest and pain medication as necessary.

Medical evidence of treatment providers

24. The evidence of treatment providers shows that Ms Bowering attended at Helensburgh Medical Centre in relation to her knee injury in 2010. Dr Turnbull performed an arthroscopy in March 2010. She continued to see her general practitioner throughout 2010 and, by April 2011, resumed her pre-injury duties.

25. The next clinical record concerning her knee is in March 2016 when she saw Dr Robert Molnar, orthopaedic surgeon, for review. It appears she was also referred to Dr Turner in September 2016 but, for reasons which are not clear, it does not appear she actually saw him.

26. The next record appears to be in early 2019 when Ms Bowering saw Dr MacDessi, who recommended a total knee replacement.

27. The various records and reports are set out below in more detail.

Dr Turnbull

28. Dr Turnbull provided a number of reports. On 12 March 2010 he reported to Dr Trevor Kemper at Helensburgh Medical Centre that an MRI showed Ms Bowering had several chondral lesions in the knee “but the most significant pathology would be the medial meniscal tear” and he would perform an arthroscope.

29. On 19 March 2010 Dr Turnbull reported to the respondent that Ms Bowering had a chondral lesion in the medial femoral condyle; if the pain from it did not settle there was a possibility of needing more extensive surgery in the future but the present plan was to deal with the meniscal pathology and see if she had pain remaining from the chondral lesion.

30. Following surgery on 31 March 2010, Dr Turnbull reported to Dr Kemper that a tear in the posterior third of the medial meniscus had been resected. There were Grade lll chondral changes on the patella and Grade lll/IV chondral changes in the patellofemoral groove. There was also an area of Grade lII/IV chondral change on the medial femoral condyle. Dr Turnbull said Ms Bowering should get significant relief from removal of the meniscus but it was likely that she would have some ongoing symptoms due to the chondral changes.

31. On 20 April 2010, Dr Turnbull reported that Ms Bowering could return to work on an "as pain permits basis", and he would review her in four months to see how her arthritis was progressing.

32. On 31 July 2010, Dr Turnbull reported to the employer the results of the MRI and the arthroscopy on 31 March 2010. A new x-ray showed medial compartment osteoarthritis. He reported that Ms Bowering might require further surgery but it was too early to say. Some of the chondral changes in the medial compartment were age-related wear and tear but it was likely they had been aggravated and accelerated by the fall and the meniscal pathology.

33. On 27 July 2010, Dr Turnbull reported that, six [sic] months post-surgery, Ms Bowering had not had a lot of improvement and continued to have activity-related pain due to the arthritis in the medial compartment. To fix her problems she would need to consider extensive surgery such as some form of arthroplasty but neither she nor he thought the pain was bad enough to take that step.

Dr Annett

34. On 3 August 2010, Dr Kemper referred Ms Bowering to Dr Paul Annett, sports physician, noting that she had ongoing pain and was unable to return to her pre-injury duties, and requesting his opinion on "optimal management" and recommendations to aid her recovery.

35. Dr Annett reported to Dr Kemper on 24 August 2010 that Ms Bowering's x-rays showed some very early degenerative change in the medial compartment, and the MRl confirmed degenerative change mainly in her patellofemoral joint. Her progress had been slow but she appeared to have "turned a corner". Continued treatment would involve restrengthening exercises and gradually increasing her general activity level with exercise, bike riding and walking. She should gradually increase the time she could work continuously on a register, but it could take another three months before she would be comfortably working her normal duties.

Physiotherapy reports

36. On 11 January 2011, Tonia Pavey, physiotherapist, reported to Dr Kemper that Ms Bowering reported "little pain today" but was still having "flare-up" days. She could progress to five hours a day, five days a week, on permanently modified duties.

37. An Initial Assessment Report dated 5 April 2011 by Peak Conditioning recommended she be provided with "an individually tailored home based program" so that she could "self-manage her condition for the long term".

Dr Molnar

38. On 9 March 2016, Dr Robert Molnar, orthopaedic surgeon, reported to Dr Cindy Htet that Ms Bowering reported a good response from the arthroscopy at the time but she was told that ultimately she would need knee replacement surgery if she had ongoing symptoms. She came to him about her options.

39. Dr Molnar undertook a clinical examination and noted that x-rays clearly showed moderately advanced arthritis predominantly affecting the medial compartment on the right side. He said he had explained her options but no small procedure would cure arthritis and, ultimately, she would need knee replacement surgery when her symptoms warranted. At the time, her symptoms once again seemed to have settled. If they recurred to the point where she was significantly disabled, a repeat MRI scan would be reasonable, but non-operative measures to avoid knee replacement at this stage would be reasonable.

40. On 16 December 2016, Dr Molnar reported to Dr Htet that a further MRI demonstrated moderately advanced osteoarthritis predominantly affecting the medial and patellofemoral compartments; there was no associated subchondral bone marrow oedema with the chondral loss, but a significant tear in the medial meniscus. He had explained to Ms Bowering that, if she was having significant mechanical symptoms, consideration for arthroscopy would be reasonable, but for most patients meniscal symptoms settle without the need for operative intervention. At this stage, she felt her symptoms were manageable and she was happy to continue with non-operative measures.

Dr MacDessi

41. Dr Samuel MacDessi, orthopaedic surgeon, reported to Dr Cindy Htet on 1 April 2019 that he saw Ms Bowering for assessment of advanced knee osteoarthritis. He took a history that she did not improve a lot following surgery, and she was told then that she had osteoarthritis in her knee. Over the last nine years she had worsening arthritic knee pain, predominantly anteromedial. She had difficulty with prolonged standing, walking and climbing stairs and occasionally it woke her at night. She had reduced her exercise because of pain. Paracetamol gave minimal symptomatic relief. She had difficulty going to the gym but still tried to exercise with water-based exercise.

42. Dr MacDessi noted that plain x-rays confirmed moderate to severe medial compartment osteoarthritis which was worsening, and Ms Bowering was keen to explore total knee replacement which was planned for mid-July. He said “as this is a work injury” she would need approval from the insurer, but he did not comment directly on causation.

General practitioners’ records

43. Records from Helensburgh Medical Centre show Ms Bowering attended there on 8 February 2010, the day of the injury. Dr Daisy Dai recorded she had twisted her right knee at work, “no falls” and “possible soft tissue injury”.

44. On 10 February 2010, Dr Kemper recorded the pain had increased and “possible meniscal tear”. On 24 February 2010, he noted persisting symptoms, positive McMurray’s test and that she would need orthopaedic review. On 31 March 2020, Dr Turnbull performed an arthroscopy.

45. On 27 April 2010, Dr Kemper noted “not healing as planned” and a follow up MRI was due in four months. On 11 May 2010, he recorded “aim to return to restricted duties next week”. On 26 May 2010, she was “improving steadily – but slowly”. On 9 June 2010, “Tonya” (the physiotherapist) had suggested “an hour standing initially at a time and building up” because of pain after standing for 15 to 20 minutes. On 22 June 2010, Dr Kemper noted “pain in the knee recurring” and that she had been given exercises and stretches by the physiotherapist who recommended specialist review if not improving.

46. On 2 August 2010, Dr Kemper recorded that pain had been a problem and Ms Bowering was taking painkillers, usually after being on her feet during the day. On 17 August 2010, he recorded she was due to see Dr Annett the following week; her knee “does feel to be improving” and she felt she had “turned the corner”.

47. On 6 September 2010, Dr Kemper noted Dr Annett's report and recorded "progress within expected and no plan to alter current treatment – though alternatives to joint replacement failing improvement detailed." On 20 September 2010, he noted she had increased her hours on the cash registers, "symptoms progressing well – is walking and exercising regularly including stationary bike at home – pain in the knees – but nothing too taxing".

48. On 12 October 2010, Dr Kemper noted Ms Bowering had a "slight step back" following physiotherapy which had "aggravated things a little more than anticipated". On 10 November 2010, she had increased her hours at work, was still having some problems with the knee and had modified some exercises. By 8 December 2010, the knee was "progressing well" though a little more irritated in the past two days.

49. Records for 12 January 2011 show Ms Bowering was to increase to five hours per day, five days a week, with restrictions. On 1 February 2011, the knee was "generally good", she had occasional bad days "but not so often now". Throughout February and March 2011, she appeared to have been progressing well. On 5 April 2011, Dr Kemper thought she was fit to return to work without restrictions and noted a call from Peter McMullen, physiotherapist, regarding a gym training program for the next month.

50. On 18 May 2011, Dr Kemper recorded notes of a case conference and that Ms Bowering had been "progressing well over the past month", pain was "very well controlled" and she could "continue with the program now independently". He noted she had been able to do "extra work and overtime at work now without problems."

51. The next record at the medical centre was on 16 February 2013 when Ms Bowering saw Dr Annette Beaufils about an unrelated matter.

52. On 21 July 2014, Ms Bowering saw Dr Hyun Ahn about a shoulder injury at work. Dr Ahn recorded "no ongoing medical problems or workcover claims". Further visits throughout 2014 refer to the shoulder injury. Ms Bowering attended five times throughout 2015. There is no reference to knee pain.

53. On 3 February 2016, Ms Bowering saw Dr Cindy Htet complaining of pain in her right knee and swelling. Dr Htet referred her to Dr Molnar and for x-ray which showed "mild to moderate medial compartment OA in both knees."

54. On 20 September 2016, Ms Bowering presented with "recurrence of R knee pain". Dr Brendan Leslie noted she had sought a second opinion earlier in the year and saw another orthopaedic surgeon (apparently a reference to Dr Molnar). He noted "needs TKR" and "asked if I think we should reopen wc case; I suggested no if the primary cause is os".

55. On 28 September 2016, Dr Annette Roberts referred Ms Bowering to Dr Turnbull again, stating she had constant pain in her right knee which kept her awake at night. Dr Roberts referred to the 2010 meniscal tear, noting "at the time you thought she may eventually need a knee replacement". For reasons which are not clear, Ms Bowering did not attend on Dr Turnbull.

56. On 22 January 2019, Dr Htet referred Ms Bowering to Dr MacDessi, noting she hurt her knee at work "years ago".

Medico-legal opinions

Dr Rimmer

57. Dr Stephen Rimmer, orthopaedic surgeon, saw Ms Bowering for the respondent on 14 October 2019.

58. Dr Rimmer recorded the circumstances of Ms Bowering's injury, and subsequent arthroscopy and physiotherapy, that she returned to pre-injury duties by March 2011 and her claim was closed in 2012. He said the "next date of note" was 16 February 2016 when she resigned to be a full time carer. Next, he recorded, sometime in 2018 she complained of pain and swelling in her right knee and was referred to Dr MacDessi. Dr Rimmer noted her current treatment was the occasional anti-inflammatory medication, and she had recently commenced exercise physiology.

59. Dr Rimmer noted that scans in 2016 and 2019 showed moderate medial compartment and patellofemoral degenerative osteoarthritis. He diagnosed constitutional degenerative osteoarthritis right knee which, he said, was consistent with her presentation of complaints and symptoms but not the injury history.

60. In response to the question whether the original incident accorded with Ms Bowering's current pain condition in terms of mechanism of action, and whether it remained a material contribution to that condition, Dr Rimmer said it did not. This, he said, was confirmed by the following facts: she returned to pre-injury duties by March 2011; her claim was closed in 2012; she was basically asymptomatic up until 2018.

61. Dr Rimmer considered the proposed total knee replacement an "appropriate management intervention" but he did not consider the insurer liable. He concluded:

> "The mechanism of injury from the 08/02/2010 would be consistent with a minor aggravation of the pre-existing degenerative osteoarthritis which was present at this time. It would be normal to expect this minor aggravation to have resolved within approximately a three month time period which essentially is confirmed by the fact that she had returned to pre-injury duties by March 2011."

Dr Bodel

62. Dr James Bodel, orthopaedic surgeon, saw Ms Bowering for assessment on 18 February 2020. He took a history of the injury and subsequent treatment and reviews.

63. Dr Bodel recorded that Ms Bowering gradually cut back her hours in 2015 and eventually ceased work in 2016 to care for her parents at which time she was working about 10 hours a week. He recorded that the arthroscope helped the knee to settle but recovery was slow and Dr Turnbull told her that, longer term, she would need to consider a replacement. She slowly deteriorated over time; she continued on light duties then went back to her normal role but on reduced hours as she was giving more time to her parents. She then resigned in 2016.

64. Dr Bodel reported that the right knee had slowly deteriorated over time, and Ms Bowering was keen to have the surgery proposed by Dr MacDessi. On examination, she had difficulty rising from a seated position because of pain in both knees. He concluded she had a twisting injury to the region of the right knee on 8 February 2010 in the manner she described. She tore her meniscus and aggravated degenerative change. The proposed surgery was reasonably necessary for management of her injury.

65. As to whether the surgery was required as a result of her injury, Dr Bodel said Ms Bowering was never asymptomatic. She returned to work and was cleared for normal duties but she has steadily deteriorated. There has been no other accident or injury. The ongoing disability in the knee was a result of the workplace injury. He said:

> "At least in part the "injury" is the aggravation, acceleration, exacerbation and deterioration of a disease process in the right knee being osteoarthritic change and that is work related. The nature and conditions of her work has caused aggravation, acceleration, exacerbation and deterioration to that disease process."

The respondent's submissions

66. Mr Baker submits that there is no dispute that Ms Bowering needs the surgery recommended by Dr MacDessi. Dr Turnbull said in 2010 that she had osteoarthritis and would eventually need surgery.

67. Mr Baker submits that Ms Bowering resumed her pre-injury duties by March 2011 and continued doing them until she resigned in 2016 for reasons unrelated to any condition in her knee. It was not until October 2019 that she lodged her claim in respect of the total knee replacement.

68. Ms Bowering says in her first statement that her knee had been getting worse over the previous six years, that is from around 2014, more than three years after the original episode and more than two years after she returned to pre-injury duties. She saw Dr Molnar in 2016 but it was not until 2019 that she went to Dr MacDessi. Mr Baker submits that it appears, from her supplementary statement, that there was a significant worsening of her knee between 2016 and 2019.

69. Mr Baker submits that Dr Turnbull's operation report shows that, as well as a meniscal tear, Ms Bowering had significant chondral changes. He thought she should get significant relief from removal of the meniscus but it was likely that she would have some ongoing symptoms due to the chondral changes, that is, due to the osteoarthritis rather than the simple twist on 8 February 2010. On 27 July 2010, Dr Turnbull reported that she had not had a lot of improvement with the arthroscope and continued to have activity related pain due to the arthritis in the medial compartment.

70. Mr Baker submits that Dr Turnbull saw the osteoarthritic changes in Ms Bowering's knee and his prediction, that she would eventually require surgery, has come to pass.

71. In August 2010, Dr Annett recorded that her knee had been improving over the previous three weeks, she had used no medication for the previous two weeks, and her range of movement was well-preserved. She appeared to be "turning a corner". Mr Baker submits that is what in fact occurred.

72. By 26 May 2010, Dr Kemper recorded that Ms Bowering was improving steadily. On 22 June 2010 the pain was "still recurring". In other words, Mr Baker submits, there was recurring pain, rather than a slow and steady improvement with continuing symptoms. By September 2010 she was progressing well, with pain "at times". Her symptoms were not unrelenting, rather they had a pattern of remission and recurrence. By February 2011, she was generally good, taking no medication, and working 25 hours a week, consistent with osteoarthritis. By March 2011, she resumed her pre-injury duties.

73. Ms Bowering did not see her doctor again until February 2013 for an unrelated matter. In July 2014, Dr Ahn recorded "no ongoing medical problems or workcover claims". There is no reference to her knee. Mr Baker submits her knee was completely quiescent throughout. The recurrence in 2016 is the first reference to her knee since 2011.

74. Dr Molnar in 2016 recorded that Ms Bowering had a good response at the time to the arthroscopy, consistent with Ms Bowering's first statement, and with Dr Turnbull's and the general practitioners' records. Dr Molnar noted that "once again" her symptoms had settled.

75. The radiological scans show the progress of the osteoarthritis that was present in 2011. The MRI in October 2016 showed a complex tear. In the absence of evidence of a further accident, it had to be degenerative because Dr Turnbull had recepted the earlier tear.

76. Mr Baker submits I would have grave reservations about the history of unrelenting symptoms provided by Ms Bowering. Dr MacDessi in 2019 reported it had been worsening over the past 10 years, compared with Dr Molnar's report in 2016 that she was essentially pain-free, and with her first statement to the effect that it had been getting gradually worse since 2014. The history taken by Dr MacDessi is manifestly wrong. In any event, he said she had worsening arthritis, as Dr Turnbull predicted she would. Moreover, the 2019 x-ray showed mild lateral subluxation and varus angulation, additional features not seen on the 2010 and 2016 scans, and tricompartmental damage inconsistent with the 2011 twisting injury.

77. Mr Baker submits that Dr Bodel says Ms Bowering's knee steadily deteriorated over time but fails to say that she increased her hours over time and was in fact doing over time. He did not have the general practitioners' history. He notes that she reduced her hours until she ceased but not that it was for unrelated reasons. He said she had steadily deteriorated in line with the natural history of the disease caused by her injury but this is not correct. He says she was never asymptomatic but that is not correct. His opinion does not sit in a fair climate of what is known of the actual history. Dr Bodel also says the nature and conditions of her employment caused an aggravation but that is not the claim.

78. Mr Baker submits that, unlike the other doctors, Dr Rimmer checked both Ms Bowering's knees and recorded symmetrical range of movement. We know it took longer for her to recover than three months as he expected but it nevertheless resolved. His opinion is in a fairer climate than either Dr Bodel or Dr MacDessi.

The applicant's submissions

79. Mr Moffet submits that there is no dispute that Ms Bowering has osteoarthritis in both knees, the difference being that the left does not need replacing because it was not aggravated in the incident on 8 February 2010. The evidence is clear that the 2011 injury made a material contribution to the need for the right knee replacement.

80. Mr Moffet submits that, once twisted, as it was, damage was caused throughout the knee and was not confined to the medial compartment. Consistent with a twisting injury, Dr Turnbull noted on 9 March 2010 that Ms Bowering had pain in the medial and lateral compartments, which he suspected was due to a meniscal tear but which would be confirmed on MRI. The MRI ultimately confirmed a medial tear.

81. On 12 March 2010, Dr Turnbull reported Mr Bowering had several chondral lesions in the knee but the most significant pathology would be the medial meniscal tear. He did not express an opinion on the cause of either. On 19 March 2010, he did not suggest the lesions were unaffected by the twisting injury. In any event, Mr Moffet submits, the issue is not whether she had ongoing symptoms but what was their cause.

82. Dr Turnbull's report of 20 April 2010 shows he anticipated Ms Bowering would have ongoing pain following her injury because he was happy for her to return to work on "an as pain permits basis". In July 2010 (four months after surgery, not six as his report indicates), there was not a lot of improvement and, as he foreshadowed in his operation report, she continued to have pain in the medial aspect.

83. Mr Moffett submits that there is no suggestion that, before her injury, Ms Bowering had any of the symptoms she had after that date. Her symptomatic knee is a direct result of that incident. Dr Turnbull said at the time that the only way to deal with her symptoms would be, eventually, a total knee replacement. If he thought the pain would resolve, he could be expected to say so.

84. On 31 July 2010, Dr Turnbull stated clearly that, while some of the chondral changes in the medial compartment were age-related wear and tear, it was "likely they had been aggravated and accelerated by the fall and the meniscal pathology." Mr Moffet acknowledges there is no reference in the evidence to a "fall"; he submits that one can assume Dr Turnbull "mis-spoke" in that regard, but Dr Turnbull says the injury aggravated and accelerated the underlying chondral changes. He foreshadowed a knee replacement would be needed. Consistent with Dr Turnbull's report, Dr Annett said that, if it did not settle, a replacement would be needed.

85. Mr Moffett submits that there is no suggestion that Ms Bowering had fully recovered when she returned to work; she was doing the best she could. She was continuing with physiotherapy and exercise. Dr Molnar in 2016 reported that her symptoms appeared to have settled once again and, in December 2016, she felt they were "manageable". The MRI in 2016 showed a big increase in the degenerative pathology. Dr Molnar recorded that she had pain in the medial aspect on standing. She saw him because she was having symptoms and she wanted to know her options. She was a prudent and cautious patient.

86. In Mr Moffet's submission, Dr Rimmer's report is brief and flawed. He assumed Ms Bowering had no further symptoms until 2018 but overlooked that she saw doctors again in 2016. (I note that it is possible Dr Rimmer meant 2019, when Ms Bowering saw Dr MacDessi, but nothing turns on this). He said it would be normal for a "minor aggravation" to settle within three months but he does not engage with the evidence that it did not. Nor does he say why it was a "minor" injury when it required arthroscopy.

87. Mr Moffett submits that Dr Bodel is an experienced orthopaedic specialist. He clearly "misspoke" when referring to the nature and conditions of Ms Bowering's employment because he does not suggest they in fact made any contribution. He took a proper history including how the twisting injury occurred. He finds the need for knee replacement is a direct consequence of the injury.

88. Ms Bowering told Dr MacDessi she had had worsening pain for the past 10 years. Mr Moffet submits that there is no reason not to accept what she says. It is not inconsistent with her first statement, and it was consistent with Dr Turnbull's and Dr Annett's projections. By the time she saw the fourth specialist, Dr MacDessi, she decided she should proceed with surgery. The clinical notes cannot be elevated to the point that they contradict four specialists. All show pre-existing osteoarthritis and no other cause that aggravated the damage. The clinical notes do not establish that she had recovered. A reference to "recurrence" of pain is a doctor's note, it does not establish that it had settled meanwhile, and it would be contrary to Dr Turnbull's prognosis if it did.

The respondent's submissions in reply

89. In reply, Mr Baker submits that there is no evidence of any problem with Ms Bowering's right knee after May 2011 when Dr Kemper recorded that she was able to do extra work and overtime "without problems". Dr Ahn's notes in 2014 shows she was asymptomatic then, and it would be disingenuous to suggest she would not have complained if she was.

Consideration

90. Section 60 of the 1987 Act relevantly provides:

> "(1) If, as a result of an injury received by a worker, it is reasonably necessary that:
> (a) any medical or related treatment (other than domestic assistance) be given, or
> (b) any hospital treatment be given, or
> (c) any ambulance service be provided, or

(d) any workplace rehabilitation service be provided,

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)."

91. In *Diab v NRMA Ltd*[1] Roche DP, referring to the decision in *Rose v Health Commission (NSW)*[2], set out the test for determining if medical treatment is reasonably necessary as a result of a work injury at [76]:

> "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:
>
> 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.'"

92. In *Murphy v Allity Management Services Pty Ltd*[3] Roche DP (considering the relevance of a subsequent non-work injury in a s 60 claim), said at [57]-[58]:

> "Moreover, even if the fall at Coles contributed to the need for surgery, that would not necessarily defeat Ms Murphy's claim. That is because a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973) 47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cluff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act.
>
> Ms Murphy only has to establish, applying the commonsense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary 'as a result of' the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40] – [55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."

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[1] *Diab v NRMA Ltd* [2014] NSWWCCPD 72
[2] *Rose v Health Commission (NSW)* [1986] NSWCC 2; (1986) 2 NSWCCR 32
[3] *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49

93. Ms Bowering bears the onus of proof. The standard is on the balance of probabilities, which means I must feel an actual persuasion: *Department of Education and Training v Ireland*[4] and *Nguyen v Cosmopolitan Home*[5].

94. There is no dispute that Ms Bowering had degenerative osteoarthritis in her right knee prior to 8 February 2010 or that she injured her right knee in the course of her employment on that date. There is no dispute that a total right knee replacement is reasonably necessary treatment for the current condition of her knee. At issue is whether the treatment reasonably necessary as a result of her workplace injury. It falls to Ms Bowering to establish, on the balance of probabilities, that the injury in 2010 materially contributed to her need for surgery.

95. Ms Bowering has given a consistent description of how the injury on 8 February 2010 occurred when she caught her right foot and twisted her knee. There is no evidence to suggest otherwise. The medical evidence indicates that the treating and assessing doctors had a common understanding of how the injury occurred, and the resulting medial meniscal tear.

96. There can be no argument that some five years elapsed following her return to work during which Ms Bowering did not complain to her doctors about her knee. However, I accept her evidence that she continued to have pain in her knee. It might not have been "unrelenting" but I accept that it continued even if it "settled" from time to time.

97. The evidence shows that Ms Bowering did not have a lot of improvement in the months following the arthroscopy. Dr Turnbull recorded so much, and so did Dr Kemper. Whatever Dr Annett meant when he said in August 2010 that she felt she had "turned a corner", he noted that her progress was slow and it could take another three months before she could comfortably resume her normal duties. In the event it took longer and it was not until March 2011 that Dr Kemper certified her fit for pre-injury duties. That was considerably longer than the three months that Dr Rimmer said would be normal to expect.

98. Ms Bowering says she resumed her duties despite ongoing pain and symptoms. The evidence shows she was having exercise physiology for at least some time after she resumed her duties. I accept her evidence that she was given exercises which she continued to do at home. I accept her evidence that her knee continued to cause her pain, particularly after a day's work, which she continued until 2016.

99. I am not persuaded that Dr Kemper's note on 22 June 2010, "pain in the knee recurring", means there was a pattern of remission and recurrence in the sense that it had gone away. One month earlier he noted she was improving steadily but slowly, and two weeks earlier that she was having pain on standing more than 15 to 20 minutes. A month later, she felt it was improving. In that context, I am not satisfied that anything of weight can be drawn from that single comment. It well established that consideration of clinical notes must be approached with caution for the reasons observed by Basten J in *Mason v Demasi*.[6]

100. I accept Ms Bowering's evidence that, from around 2013, she was caring for her elderly parents and did not take the time to see her doctor about her knee. Two specialists had told her she would eventually need a knee replacement and she appears to have accepted that. I accept her statement that Dr Turnbull advised her to delay further surgery until she could no longer manage her symptoms. I accept that she managed the pain herself until she returned to her doctor in February 2016.

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[4] *Department of Education and Training v Ireland* [2008] NSWWCCPD 134
[5] *Nguyen v Cosmopolitan Homes* [2008] NSWCA 246
[6] *Mason v Demasi* [2009] NSWCCA 227 at [2]

101. The fact that Ms Bowering did not raise any question of knee pain during a number of visits to her doctor in 2014 and 2015 raises questions about how severe any pain was or even whether she was experiencing pain at all. However, I do not accept that Dr Ahn's notation in July 2014, "no ongoing medical problems or workcover claims", is without more, evidence that she was having no pain. I accept that she put off what she had been told was inevitable for as long as she could.

102. Dr MacDessi appears to have assumed the need for treatment resulted from Ms Bowering's workplace injury but he did not comment directly on causation and I place no weight on his opinion in that regard. However, he did note that she had difficulty going to the gym but still tried to exercise with water-based exercise as well as using a stationary bike, which lends support to Ms Bowering's claim that she managed the pain herself.

103. I do not find Dr Rimmer's opinion persuasive. He expected the injury would have resolved within approximately three months. He said this was essentially confirmed by the fact that she returned to pre-injury duties in March 2011 which was over 12 months later. He did not address why it took considerably longer than three months. Dr Rimmer also did not have the history that Ms Bowering returned to her doctor and saw Dr Molnar twice in 2016. He apparently considered the most relevant matters being that she resumed pre-injury duties in March 2011; her claim was closed in March 2012; the next "date of note" was 2016 when she resigned to care for her parents; and then sometime in 2018 she complained of pain and, in 2019, she saw Dr MacDessi. It is not clear where the reference to 2018 comes from but nothing turns on this. It still remains that Dr Rimmer considered the injury aggravated Ms Bowering's pre-existing degenerative condition.

104. Dr Rimmer noted a meniscal tear on the recent MRI but there is no medical evidence, and he does not comment, on when or how it might have occurred. In the absence of medical evidence, there is no way of knowing what, if any, relationship it had to the workplace injury.

105. I accept that there are some difficulties with Dr Bodel's opinion in that he did not have the full history of gaps in presentation to doctors. He also had a sketchy picture of Ms Bowering's working hours. It appears he thought she never resumed full hours because she was helping her parents. He said she reduced her hours from 20 hours down to 10 hours until she ceased work in 2016 to care for her parents. His report does not state that she ceased work because of pain in her knee. Nevertheless, he took a history broadly consistent with Ms Bowering's claim that she continued to experience the pain in her knee.

106. Dr Bodel concluded that the injury "at least in part" caused the aggravation, acceleration, exacerbation and deterioration of the disease process in the right knee being osteoarthritic change. His opinion is consistent with Dr Turnbull's. Dr Bodel's reference to nature and conditions is confusing but, read in context of clear reference to the injury on 8 February 2010, it appears he "misspoke". I am not persuaded it undermines his opinion generally.

107. There is no evidence that the osteoarthritis seen on the MRI in 2010 gave Ms Bowering any symptoms or pain before her injury. In 2010, Dr Turnbull considered the most significant pathology was the medial meniscal tear, more so than the several chondral lesions in the knee. In his opinion, some of the chondral changes in the medial compartment were age-related wear and tear but it was likely they had been aggravated and accelerated by the injury and the meniscal pathology. He and Dr Annett considered a total knee replacement would be necessary in time. Neither suggests that the injury played no part.

108. Considering all of the evidence, I am satisfied, on the balance of probabilities, that the injury in 2010 materially contributed to the reasonably necessary treatment recommended by Dr MacDessi.

SUMMARY

109. In conclusion, I am satisfied that the injury on 8 February 2010 materially contributed to Ms Bowering's need for a total right knee replacement.

110. I am satisfied on the balance of probabilities that the treatment proposed by Dr MacDessi, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of Ms Bowering's employment with the respondent on 8 February 2010.