WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: 2009/20
Applicant: Gregory John Morrison
Respondent: ACFS Port Logistics Pty Ltd
Date of Determination: 18 August 2020
Citation: **[2020] NSWWCC 278**

The Commission determines:

1. The applicant suffered a consequential condition to his lumbar spine.

2. The proposed surgery is reasonably necessary.

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

E BEILBY
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 E BEILBY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Gregory Morrison (the applicant) commenced his employment with ACFS (the respondent) in 2008. The applicant considered himself to be in good health at that time.

2. On 23 February 2012, the applicant was in the course of his employment when he lost his footing on a truck causing him to slip and fall, twisting his right knee. There is no issue the applicant injured his right knee as reported.

3. The applicant consulted with his general practitioner, Dr Brody, General Practitioner at Botany Medical Centre, who referred the applicant to Dr Michael Solomon (orthopaedic specialist). The applicant first consulted Dr Solomon on 5 March 2012.

4. Dr Solomon recommended an MRI scan of the right knee and then arthroscopic surgery.

5. On 17 March 2012, the applicant underwent a right knee arthroscopy performed by Dr Solomon. The applicant then participated in hydrotherapy and took some two months off work.

6. In September 2012, the applicant reinjured his right knee when he knocked his knee getting out of a truck. He reported this to his supervisor.

7. The applicant says that over time his right knee gradually deteriorated. He observed he was limping and would get swelling and pain in the knee.

8. In mid-2014, the applicant says that he began to notice pain and symptoms in his left knee. He felt that this was because he was compensating for his right knee with the left knee and felt he was walking with a limp. The applicant once again consulted Dr Solomon in respect of his knee condition.

9. The applicant explains that when he returned to work, he would often when getting in and out of the trucks he would land on his left leg to protect his right knee.

10. The applicant underwent an MRI of his left knee on 12 June 2014 which illustrated a complex multi-directional tear. Dr Solomon did not think that surgery was indicated at that stage.

11. On 21 September 2017, the applicant lodged a recurrence of injury claim as his right knee was continuing to cause him pain and was “continuously swollen”.

12. In September 2017, the applicant was referred to Dr David Broe in respect of his right knee.

13. In November 2017, the applicant underwent a total right knee replacement performed by Dr Broe and then rehabilitation treatment.

14. Mr Morrison first consulted Professor Papantoniou on 19 September 2019. Professor Papantoniou referred the applicant for a CT and an upright MRI of his lumbar spine. The applicant felt claustrophobic so could not have the MRI scan, but underwent the CT scan.

15. After reviewing the CT scan Professor Papantoniou recommended that the applicant undergo surgery by way of L4-S1 instrumented fusion. He has explained that this is a two-step surgery where the L5/S1 fusion would take first, and then after a few months the L4/L5 level fused.

16. The applicant wishes to undergo the proposed surgery.

ISSUES FOR DETERMINATION

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

    (a) Does the applicant have a consequential condition in his lumbar spine?

    (b) Is the proposed surgery requested by Prof Papantoniou (on 17 October 2019) reasonably necessary?

PROCEDURE BEFORE THE COMMISSION

18. The parties attended an Arbitration on 3 July 2020. 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

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

    (a) Application to Resolve a Dispute and attached documents (the Application);

    (b) Reply to the Application to Resolve a Dispute (the Reply);

    (c) Late documents dated 3 June 2020 and 25 June 2020.

Oral Evidence

20. There was no application to adduce oral evidence.

MEDICAL EVIDENCE DISCUSSED

Treating Medical Evidence

Professor Papantoniou

21. Professor Papantoniou is the applicant's treating spinal surgeon[1]. He first examined the applicant in late 2019. He took a history from the applicant that in the events of 2012 the applicant landed heavily on his buttocks injuring his lower back.

22. The applicant complained to Professor Papantoniou of left-sided lower back pain radiating to the left buttock and the left posterior thigh. There was also pain in the left calf on the lateral aspect of the left foot in the left S1 distribution.

23. Professor Papantoniou opined that the applicant injured his L5/S1 disc when he fell on to his buttocks.

24. In a report dated 17 October 2019[2], Professor Papantoniou had the benefit of looking at the applicant's recent CT of his lumbar spine which demonstrated L5/S1 disc degeneration with loss of height and at L4/5 there was a gaseous formation within the disc as well as loss of disc height with a posterior disc bulge.

[1] Application page 113
[2] Application page 116

25. Professor Papantoniou opined that the applicant suffered an L5/S1 and L4/5 disc injury as a direct result of the work injury. The Professor has a history that the pain began when the applicant fell from the truck, that is in 2012. Professor Papantoniou says that there was probably some minor pre-existing pathology but did not affect his normal work activities and as such he thought that the injury in 2012 should be characterised as an aggravation or acceleration of his pathology with the aggravation had not ceased. Professor Papantoniou then expresses his opinion that the proposed surgery is required in a two stage process and that the applicant should be cautious with lifting, bending and twisting activities.

Dr David Broe

26. The applicant was referred to Dr David Broe in September 2017[3] by the general practitioner, Dr Brody. The applicant had at that stage undergone a knee arthroscopy but was experiencing deterioration in his right knee with continuous limping and acute intermittent swelling and pain. The applicant reported that he was now compensating with his left knee joint and putting more weight on his left side which was becoming symptomatic.

27. Dr Broe opined that the applicant required a total right knee replacement which was performed by Dr Broe on 13 November 2017 and paid for by the respondent's insurer.

28. Dr Broe reviewed the applicant on 19 January 2018[4] and thought he was doing exceptionally well and was observed to be mobilising without a limp.

29. Whilst the knee was progressing exceptionally the applicant had noticed significant right-sided sciatica which the doctor opined was likely from irritation of the L5 or S1 nerve root. The applicant was also experiencing numbness over the lateral aspect of the left thigh which was consistent with a condition called meralgia parasthetica (usually associated with tightness and restriction around the lateral femoral cutaneous nerve of the thigh).

30. Dr Broe reviewed the applicant again on 18 May 2018, being some six months after the total right knee replacement. The applicant was at that stage travelling reasonably well however was noticing some pain and altered sensation in the L5 distribution of the lower leg. The doctor thought that there could be lower back pathology and radicular nerve pain however an MRI scan was required.

31. The applicant was unable to undergo the MRI scan due to a claustrophobic condition however did have a CT of his lumbar spine.[5] The CT disclosed that the applicant had a multi-level lower lumbar spondylosis with a right paracentral disc protrusion impinging on the descending right L5 nerve.

32. Dr Broe once again reviewed the applicant on 26 June 2018.[6] Dr Broe understood the applicant was having significant associated symptoms down his right lower limb which the doctor thought was secondary to his gait imbalance and associated limping. That is, it was Dr Broe's opinion that due to the applicant's limping which had been present for many years, he was now getting irritation of his lower back. The doctor booked the applicant in to have a CT-guided injection to see if this would assist.

33. The applicant once again returned to Dr Broe on 29 November 2018. Once again, the applicant complained of pain radiating down the lateral aspect of the right leg, and the applicant also had some pain down his left leg with numbness in the L5/S1 distribution. Dr Broe opined that the applicant's pain was arising from the lower lumbar spine which was neuropathic in origin.

[3] Application page 139
[4] Application page 151
[5] Application page 158
[6] Application page 160

34. The applicant was again reviewed by Dr Broe in June 2019[7] for the purposes of a WorkCover report.[8] Dr Broe clearly outlines the applicant's treatment which includes the arthroscopy and the knee replacement. Dr Broe observed that the applicant's post-operative recovery had been complicated predominantly by right-sided lower back pain and associated radiculopathy.

35. Dr Broe commented that there was no doubt that the right knee joint was related to the initial workplace injury but he stated "I am not sure with regards his lumbosacral spine as it is very degenerative in nature".[9]

36. This comment however needs to be read with a further observation by Dr Broe that the applicant had been limping for many years and this had irritated the lower back. To my mind, Dr Broe does not link the lumbar spine to the original injury in the sense of a frank injury but supports the applicant's case as to the aggravation of an underlying condition in the lumbar spine.

Dr John Harrison

37. The applicant was examined by Dr John Harrison, orthopaedic surgeon, in November 2018[10]. In respect of the applicant's treatment and symptomatology he notes that the applicant's right knee began to swell and he was limping and protecting his right leg immediately after the accident. The applicant then had aggravating injuries associated with accessing and egressing from different trucks and continued to limp with recurrent patterns of swelling in that knee.[11] The applicant told the doctor that he was conscious of mechanical back pain still affecting him.

38. On examination, Dr Harrison observed that when the applicant was standing and walking, he had a slight varus alignment of the right knee when load bearing through the step through phase of gait with buckling or dynamic varus tilt apparent in the right knee consistent with more advanced medial compartmental wear being on that side. Dr Harrison opined that the applicant had a 5% impairment of his lumbar spine however does not make a clear and obvious connection as that being a consequential condition to the limping.

39. In a further report dated 26 August 2019[12], Dr Harrison responds to the opinion of Dr Stephen Rimmer. Dr Harrison then opines that the applicant's original injury to his right knee with an acquired tendency to limp that persisted from then and caused the antalgic gait. It is the doctor's opinion that the applicant clearly appears to have aggravated pre-existing degenerative changes in the lower part of his back.

40. Dr Harrison also put some significance on the applicant's weight gain of some "30kg". This increased weight increases the prospect that asymptomatic lumbar degenerative disc disease will be exacerbated and made more symptomatic (though this is an argument not pursued at Arbitration).

[7] Application page 162
[8] Application page 160
[9] Application page 164
[10] Application page 58
[11] Application page 59
[12] Application page 70

Dr Renata Abraszko

41. Dr Abraszko prepared a medico-legal report at the request of the applicant's solicitors after an examination on 11 December 2019.[13] At that stage Dr Abraszko understood that the applicant had suffered a work-related injury to his right knee when he slipped and fell off a truck twisting his right knee. Dr Abraszko took a history that the applicant had pain in his right knee which had caused him to walk sparing the right leg and putting extra stress to his spine, hips and the left leg. Dr Abraszko opined that this had caused the beginning of back pain and pain in the left knee.

42. Dr Abraszko took a history of progressive back pain and swelling of the right knee and also the surgery performed by Dr Broe in November 2017. The applicant told Dr Abraszko he had constant back pain and was compensating over the years for painful right knee problems and developed left knee pain and progressive lower back pain.

43. It should be observed that Dr Abraszko does not appear to put any time in particular as to the onset of back pain.

44. Dr Abraszko had the benefit of the CT of the lumbar spine in September 2019 which revealed a vacuum phenomenon at L4/L5 level and a spontaneous anterior fusion at L5/S1. Dr Abraszko understood the applicant had undergone steroid injections with no improvement and physiotherapy likewise which did not assist the applicant. Dr Abraszko understood that Prof Papantoniou recommended a staged posterior L4/S1 fusion beginning with the L5/S1 followed by the L4/5 fusion.

45. Dr Abraszko considered the radiological investigations and concluded that there was multi-level lower lumbar spondylosis with a right paracentral disc protrusion impinging on the descending right L5 nerve. The doctor thought that a trial of CT-guided right L5 perineal steroid injection could be considered. After looking at the CT of the lumbar spine of 27 September 2019, the doctor concluded that the applicant had a focal severe degenerative discopathy and facet joint arthropy at L4/5 and L5/S1 with a potential for L4 and L5 nerve root irritation.

46. Dr Abraszko opined that the applicant suffered from back pain and left L5 radiculopathy due to L4/5 intervertebral disc injury. Dr Abraszko clearly states that this L4/L5 disc injury is also a consequence of chronic imbalance to compensate for the right knee injury acquired by the work-related accident in 2012.

47. So far as proposed treatment is concerned, Dr Abraszko thought it was unlikely that conservative management alone would significantly improve the applicant's back pain. In respect of the surgery proposed by Prof Papantoniou, Dr Abraszko thought the applicant required an L4/5 interbody fusion as suggested by Prof Papantoniou however at the L5/S1 level an interbody fusion was not required as there had been spontaneous fusion according to the recent imaging but the applicant would benefit from a nerve root decompression at L5/S1 level, bilateral foraminotomy and potentially a posterior-lateral instrumentation with pedicle screws.

48. Even though Dr Abraszko thought in her professional opinion that the proposed surgery was required at the levels suggested by Prof Papantoniou but with a slightly different operation at L5/S1, she nevertheless opined that the surgery proposed by Prof Papantoniou was reasonable and necessary for the treatment of the applicant's back pain and that the type of success would be around 70%-80%.

[13] Application page 25

Dr Stephen Rimmer

49. Dr Rimmer has prepared three reports. The first two reports are of little relevance as they take no history as to any complaint in respect of lumbar symptomatology.

50. Dr Rimmer has prepared a third report dated 18 May 2020 at the request of his solicitors.[14]

51. Dr Rimmer is quite clear in that he disagrees with the opinion of Professor Papantoniou in that when Dr Rimmer examined the applicant on two occasions, at no time did the applicant claim to have injured his lumbar spine in the incident of 23 February 2012.

52. Dr Rimmer refers to an examination of the applicant on 18 June 2014 and notes that at no time during that assessment did the applicant mention that he had injured his lumbar spine or notice the gradual onset of lumbosacral back pain following the workplace incident in February 2012. The doctor then says on the basis of the lack of complaint, he opines that there is no causal relationship between the worker's lower back symptoms and the right knee injury.[15] Dr Rimmer rather holds the opinion that the applicant's lumbar spine symptoms are due to his constitutional degenerative change and would be present regardless of his employment as a truck driver.

53. In respect of the proposed surgery, Dr Rimmer thinks that the proposed surgery is not reasonable and not necessary. He appears to base his opinion on the fact that the applicant states that his total right knee replacement made his condition worse and therefore it is Dr Rimmer's opinion that any attempt at surgical intervention to the lumbar spine would have a poor result at best.

54. I should observe that it is not the applicant's case that there was symptomatology in the lumbar spine in 2014, it is not surprising therefore that Dr Rimmer has no history in respect of it at that time.

Botany Medical Centre

55. The applicant has sought treatment and advice from his general practitioner at the Botany Medical Centre. The notes from the Botany Medical Centre have been produced. I will now outline the relevant entries.

56. On 6 August 2012, the applicant consulted Dr Brody[16] in respect of pain. It is observed that this is the first appointment following the applicant's frank incident in March 2012.

57. On 1 September 2012, the applicant consulted Dr Brody who noted that the compensation case had closed, and the applicant was doing ok and had his last physio this week.

58. On 3 September 2012, the applicant consulted Dr Brody[17] and a history was taken that the applicant knocked his right knee at work and had increased pain.

59. On 11 September 2012, the applicant consulted Dr Brody and a referral was created to see Dr Michael Solomon. The knee was still painful and as a result the compensation claim was once again opened.

60. On 13 September 2012, Dr Brody referred the applicant to have an MRI of his right knee.

61. On 21 September 2012, Dr Brody observed that the applicant had undergone the MRI scan and had swelling only.

[14] Late documents from respondent, page 1
[15] Page 2 of the report
[16] Application page 198
[17] Application page 198

62. On 12 October 2012, Dr Brody took a history that the applicant's knee had improved with "nil pain".[18]

63. On 1 November 2012, Dr Brody observed that the knee had improved, and the compensation case was now closed.[19]

64. On 3 January 2013, the applicant consulted Dr Tuon who treated the applicant for his left foot plantar fasciitis.

65. On 18 January 2013,[20] the applicant saw Dr Brody and told him that the cortisone injection had been performed and that his knee felt good after the injection.

66. On 1 February 2013,[21] Dr Brody created a letter for WorkCover and certified the applicant as fit to return to full duties as of 4 February 2013.

67. On 2 September 2013, the applicant consulted Dr Graham[22] and provided a history of hurting his lower back.

68. On 4 September 2013,[23] the applicant saw Dr Brody who thought the applicant was suffering from mechanical lower back pain which was improving. The applicant indicated he had been injured at work.

69. On 6 September 2013,[24] the applicant once again saw Dr Brody who took a history that the applicant's back pain felt better.

70. On 7 January 2014,[25] the applicant saw Dr Brody who took a history of a painful left knee as the applicant was compensating for the previous painful right knee. Dr Brody referred the applicant to have an MRI.

71. On 1 February 2018, the applicant was still complaining of a painful knee which was painful on walking. The applicant was keen to return to half day duties at work if possible.

72. On 5 March 2018, the applicant saw Dr Vyas[26] and was having pain in the herpatic area with numbness and pulling sensation.

73. On 19 March 2018,[27] the applicant saw Dr Nguyen and complained of a painful right knee and had a rash on the left side of his chest from shingles. The applicant was experiencing shingles neuralgia.

74. On 21 April 2018, the applicant complained to Dr Nguyen[28] of ongoing right knee pain with difficulty standing up after sitting. The applicant still had a rash on his left upper chest with a history of shingles at the same site.

75. On 1 May 2018, the applicant consulted Dr Brody[29] with a history of falling and hitting his right knee at work after stepping on uneven ground. Dr Brody reported the applicant was not limping at that stage and had a good gait.

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[18] Application page 200
[19] Application page 200
[20] Application page 202
[21] Application page 203
[22] Application page 205
[23] Application page 205
[24] Application page 205
[25] Application page 206
[26] Application page 218
[27] Application page 219
[28] Application page 221
[29] Application page 221

76. On 21 May 2018,[30] the applicant saw Dr Hoang and there was a request made by Dr Hoang for a CT of the lumbar spine because of lower back pain with right leg radiculopathy.

77. On 24 May 2018, the applicant saw Dr Hoang with a history of multi lumbar spine discopathy. Analgesics were prescribed.

78. On 23 July 2018, the applicant saw Dr Katenas[31] and the applicant complained of right knee pain with stiffness and decreased range of movement.

79. On 13 August 2018, the applicant saw Dr Katenas[32] and he had a flare-up of right knee pain.

80. On 18 October 2018,[33] the applicant consulted with Dr Katenas who referred the applicant to a knee orthopaedic specialist, Dr David Broe.

81. On 8 November 2018,[34] the applicant complained to Dr Katenas of ongoing right knee pain.

82. On 24 December 2018,[35] the applicant reported that he still had pain in his knee following his knee replacement in 2017.

83. On 21 January 2019, the applicant saw Dr Katenas and it was noted that the applicant had seen Dr Rimmer for the respondent's solicitors.

84. On 11 February 2019, the applicant complained to Dr Katenas of right knee pain.[36]

85. What I find is persuasive in the treating notes is the consistent complaint of right knee pain. Whilst there is little by way of complaint in respect of the lumbar spine, it is not the applicant's case that there was an early onset but rather the altered gait caused an aggravation of an underlying condition.

Discussion and Determination

86. I will now discuss and determine the consequential condition and then the dispute about surgery.

Consequential Lumbar Condition

87. The applicant must establish that she suffered a condition in the lumbar spine consequent on the injury to the right knee, that is the lumbar condition "resulted from" the right knee injury. The test to be applied is in the principle set out by Kirby P in *Kooragang Cement Pty Ltd v Bates*[37] namely:

> "It has been well recognised in this jurisdiction that an injury can set in train a series of events. If the chain is unbroken and provides a relevant causative explanation of the incapacity or deaths on which the claim comes, it will be open to the Compensation Court to award compensation under the Act."

[30] Application page 222
[31] Application page 223
[32] Application page 223
[33] Application page 166
[34] Application page 168
[35] Application page 170
[36] Application page 174
[37] (1994) 35 NSWLR 452 at 462

88. It is not necessary for the applicant to establish that she suffered an "injury" to the lumbar spine within the meaning of section 4 of the *Workers Compensation Act 1987* (the 1987 Act), only that the symptoms and restrictions in the lumbar spine resulted from the right knee injury.[38]

89. The applicant's case at Arbitration was that in 2012 the applicant fell awkwardly and suffered a twisting injury to his right knee. The right knee injury continued, and the applicant underwent an arthroscopy and ultimately a right knee replacement. Unfortunately, the applicant's right knee replacement did not resolve his symptomatology in his right knee and as such he continued to limp and walk with an antalgic gait which then caused a consequential condition in his lumbar spine.

90. There is to my mind significant evidence in relation to the applicant's limping and antalgic gait. This is supported by Dr Harrison, Dr Abraszko, Dr Broe and Dr Solomon.

91. The applicant relies heavily on the opinion of Dr Abraszko in respect of causation of the consequential condition of the lumbar spine. The reports of Dr Abraszko speak for themselves and have already been summarised.

92. The primary submission made by the respondent was that there is no subjective complaint or recorded complaint in respect of lumbar spine symptomatology until May 2018. The applicant's counsel agreed with that description as to the onset of complaint. That is that back pain symptomatology becomes prevalent after the applicant's knee replacement surgery.

93. There is indeed complaint to Dr Broe in January 2018[39] though I think the small time difference as to complaint is not relevant to the dispute.

94. The respondent then said that there is too lengthy a hiatus in complaint from the initial incident in 2012 to the onset of complaint in 2018 for them to be related. The applicant visited his general practitioner regularly and there is simply no complaint.

95. I do not feel that the delay in onset of complaint is fatal to the applicant's case[40]. The right knee injury of itself has unfortunately not resolved over time and has indeed got worse involving the applicant ultimately having what appears to be an unsuccessful right knee replacement. The right knee has been favoured, with over-reliance on the left side causing this antalgic gait which has aggravated the underlying condition in the lumbar spine. The onset of complaint is really after the total knee replacement (which is consistent with the applicant's case).

96. In some case the traverse of time may dilute the link between events, though in this present case I find no compelling reason to break the link. The link has been well explained by Dr Abrazsko in her well-reasoned reports and is also supported by a treating surgeon Dr Broe.

97. The respondent's second area of submissions is that the opinions of Professor Papantoniou, Dr Abraszko and Dr Harrison should not be relied upon because they have an incorrect history.

98. The respondent pointed to the history of Professor Papantoniou who opines that the applicant sustained a frank injury in 2012, which goes against all the applicant's case at Arbitration. I agree that in respect of the origin of the lumbar condition, Professor Papantoniou's opinion stands alone.

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[38] See Deputy President Roche in *Moon v Conmah Pty Ltd* (2009) NSWWCCPD 134 at paras 45-46
[39] Application page 151
[40] See *Seif v Secretary, Department of Family and Community Services* (2020) NSW CCPD

99. It is complained that Dr Harrison and Dr Abraszko also do not have the appropriate history. The basis of the submission appears to be an assumption made by the doctors that the onset of back pain was at an earlier stage than mid-2018. I do not agree with such a description of the doctor's opinions.

100. Dr Abraszko clearly understands the applicant has progressive back pain and at no stage in her opinion does she say that the back pain came on in 2012. In Dr Abrazsko's first report she understands that the applicant underwent a total knee replacement in November 2017 and then continued to complain of "constant back pain". Dr Abrazsko describes the back pain as "progressive back pain". Dr Abrazsko further comments;

> "This L4/5 disc injury is also a consequence of chronic imbalance to compensate for the right knee injury acquired by the work related accident in 2012."

101. I infer from that comment that the Dr Abraszko accepts a right knee injury in 201, she does not mean that the lower back injury occurred in a frank sense or that the applicant has had lumbar symptomatology since that time.

102. The applicant relies upon Dr Abraszko and I can' t find any obvious fault with the history taken by her.

103. D Broe has a clear history of the onset of pain and he clearly records its onset following the total knee replacement. I find the opinion of Dr Broe persuasive as to the link between limping and aggravation of a lumbar condition, he is a treating surgeon who has seen the applicant many times.

104. The respondent also points out that the doctors also do not have a history in relation to the applicant suffering shingles in March 2018. The medical significance of shingles appears to be based on the respondent's counsel pointing to some neuralgia appearing as a result of the shingles condition. At no stage is it identified where the neuralgia is and the shingles appear to be to my mind from the thoracic area as opposed to the lumbar. There is no medical opinion before me, indeed none placed before me by the respondent, that indicates that back pain could arise from a shingles condition. I do not find this submission persuasive.

105. It is also important to my mind to understand the applicant's case is that there has been an aggravation of an underlying process. That is, the applicant does not seek to say that the whole of the lumbar condition arises from the 2012 injury as a consequential condition. The case is that the underlying condition has been aggravated or accelerated by the limping and/or antalgic gait over the years.

106. In looking at the question of the consequential condition to the lumbar spine, there does appear to be an onset of lower back pain after the total right knee replacement. There is a significant ongoing history of the applicant walking with a limp, which accords with the opinion of Dr Abraszko and Dr Broe in respect of contributing to the consequential condition.

107. Dr Rimmer appears to not turn his mind to the real question of an aggravation of an underlying condition and as such his opinion does not provide me with any significant assistance. I therefore prefer the opinion of Dr Abrazsko over Dr Rimmer where there is a conflict.

108. In making my findings I accept that Professor Papantoniou has an incorrect history as to the onset of lumbar symptomatology (being in 2012). I find the opinions of Dr Broe and Dr Abraszko to be more persuasive for reasons outlined above.

109. The applicant has therefore discharged the burden on the balance of probabilities as to the consequential lumbar condition. I am satisfied that the altered gait has aggravated an underlying condition in the applicant's lumbar spine.

Proposed Surgery

110. I will now turn my mind to the proposed surgery.

111. Section 60 of the 1987 Act provides:

> "(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
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> (b) any hospital treatment be given, or
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> (c) any ambulance service be provided, or
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> (d) any workplace rehabilitation service be provided,
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> 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)."

112. Burke CCJ in *Rose*[41] considered what reasonably necessary treatment was in the context of section 10 of the *Workers Compensation Act 1926*[42]:

> "Treatment, in the medical or therapeutic context, relates to the management of disease, illness or injury by the provision of medication, surgery or other medical service designed to arrest or abate the progress of the condition or to alleviate, cure or remedy the condition. It is the provision of such services for the purpose of limiting the deleterious effects of a condition on restoring health. If the particular 'treatment' cannot, in reason, be found to have that purpose or be competent to achieve that purpose, then it is certainly not reasonable treatment of the condition and is really not treatment at all. In that sense an employer can only be liable for the cost of reasonable treatment."

113. In *Diab v NRMA Ltd*[43] Deputy President Roche cited *Rose* with approval. He summarised the principles as follows:

> "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 namely: (a) the appropriateness of the particular treatment; (b) the availability of alternative treatment, and its potential effectiveness; (c) the cost of the treatment; (d) the actual or potential effectiveness of the treatment, and (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective."

114. Of some assistance in determining disputes such as the present one, Deputy President Roche helpfully stated:

> "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

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[41] *Rose v Health Commission NSW* (1986) 2 NSWCCR 32 (*Rose*).
[42] Par 42.
[43] [2004] NSWCCPD 72 (*Diab*)

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."

115. It is accepted that a condition can have multiple causes, but the applicant must establish that the injury materially contributed to the need for surgery. This was confirmed by Deputy President Roche in *Murphy v Allity Management Services Pty Ltd*[44], where he stated:

> "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"…… 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 common sense 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."

116. It is quite clear that the respondent's retained expert Dr Rimmer does not think that surgery is recently necessary. Dr Rimmer also hold the opinion that the applicant has no injury to his lumbar spine and therefore does not turn his mind to proposed surgery in any meaningful way except to say because the knee replacement surgery has not been successful this surgery is also not likely to be successful.

117. I am also not persuaded by Dr Rimmer's opinion that because one surgery hasn't been successful (that is the total knee replacement) that the proposed lumbar surgery will not be successful also. This has not been explained clearly by Dr Rimmer and I find it unpersuasive.

118. The applicant relies on the opinions of Dr Abrazsko and Professor Papantoniou as to the reasonable necessity for the proposed surgery. As described earlier in this decision, there appears to be a professional difference between these two surgeons as to the precise nature of the surgery.

119. The professional difference does not cause me any difficulty in determining that the proposed surgery is reasonably necessary. It is quite common for practising surgeons to differ in their approach and at the end of the day, Dr Abrazsko concedes that the surgery as recommended by Professor Papantoniou is reasonably necessary and is likely to have a good outcome.

120. Applying the principles in *Diab*, the applicant has established that the proposed treatment is appropriate as he has the support of two practising surgeons opining that it is effective treatment for the applicant. There is no evidence before me that supports a finding of viable alternative treatment other than the surgery to the lumbar spine.

121. No submissions were made as to the cost of surgery being prohibitive and therefore, I do not take this into account in my determination.

122. No submissions were made as to the the acceptance by medical experts of the treatment as being appropriate and likely to be effective, save for the opinion of Dr Rimmer as already discussed.

123. After considering all the evidence I find that the applicant has discharged the burden of proof in respect of persuading me that the surgery is reasonably necessary.

[44] [2015] NSWCCPD 49 (*Murphy)*