WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**1252/20**
Applicant:	**Kylie Jane Easton**
Respondent:	**Secretary, Department of Communities and Justice**
Date of Determination:	**23 June 2020**
Citation:	**[2020] NSWWCC 208**

The Commission determines:

1. Award for the Applicant in respect of the surgery in the form of a right total knee replacement as proposed by Dr Verheul on production of accounts and/or receipts.

2. The Respondent pay the Applicant's section 60 expenses in the sum of $148 on production of accounts and/or receipts.

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

Jane Peacock
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 JANE PEACOCK, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

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Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. By Application to Resolve a Dispute (the Application) the applicant, Ms Kylie Easton (Ms Easton) seeks a determination that proposed surgical treatment in the form of a right total knee replacement as proposed by her treating surgeon Dr Verheul is reasonably necessary as a result of injury to her right knee on 11 October 1997.

2. The respondent is the Secretary, Department of Communities and Justice (the Department). The Department was insured at the relevant time by QBE TMF for the purposes of workers compensation.

3. The Department denied liability for the claim for the proposed surgery.

ISSUES IN DISPUTE

4. There is no dispute that Ms Easton suffered an injury to her right knee on 11 October 1997.

5. She reported the injury and was placed on light duties for a period of time after that injury.

6. She has subsequently been paid weekly compensation for a closed period and treatment expenses in respect of that injury.

7. Ms Easton now seeks to have a right total knee replacement as recommended by her treating specialist Dr Verheul.

8. The Department disputes that the proposed surgery is reasonably necessary as a result of the injury on 11 October 1997 and disputes that the proposed surgery is reasonably necessary at all. The Department seeks that an award be made in its favour.

9. In the event Ms Easton is successful, the parties agree that orders would be made as follows:

   (a) Award for the Applicant in respect of the surgery in the form of a right total knee replacement as proposed by Dr Verheul on production of accounts and/or receipts.

   (b) The Respondent pay the Applicant's section 60 expenses in the sum of $148 on production of accounts and/or receipts.

PROCEDURE BEFORE THE COMMISSION

10. The parties attended a conciliation arbitration by telephone on 30 April 2020. The parties were both legally represented by counsel. Ms Easton was represented by Mr McMahon of counsel instructed by Mr Brown and the Department was represented by Mr Grimes of counsel instructed by Mr Maakasa and Ms Sadona appeared from the insurer. Conciliation took place however the parties were unable to come to a resolution of the matter. I'm 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've 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 entire dispute.

EVIDENCE

Documentary evidence

11. The following documents filed on behalf of each party were admitted into evidence before the Commission by consent and taken into account in making this determination:

For Ms Easton:

(a) The Application and all documents attached.

For the Department:

(a) The Reply and all documents attached, and
(b) The Late documents filed with an Application to Admit Late Documents dated 23 April 2020.

Oral evidence

12. Ms Easton did not seek leave to adduce further oral evidence.

13. The Department did not seek leave to cross-examine Ms Easton.

FINDINGS AND REASONS

14. There is no dispute that Ms Easton suffered an injury to her right knee on 11 October 1997. She reported the injury and was placed on light duties for a period of time after that injury. She has subsequently been paid weekly compensation for a closed period and treatment expenses in respect of that injury.

15. Ms Easton now seeks to have a right total knee replacement as recommended by her treating specialist Dr Verheul.

16. The Department disputes that the proposed surgery is reasonably necessary as a result of the injury on 11 October 1997. The Department disputes that a right total knee replacement is reasonably necessary surgery at all.

17. I must determine, on the balance of probabilities, whether the proposed surgery in the form of a right total knee replacement as recommended by the treating surgeon Dr Verheul is reasonably necessary as a result of injury on 11 October 1997. This determination must be made on the evidence and in accordance with the law.

18. Section 60 (1) of the 1987 Act provides as follows:

“60 Compensation for cost of medical or hospital treatment and rehabilitation etc

(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)."

19. Deputy President Roche in *Diab v NRMA* [2014] NSWWCCPD 72 (*Diab*) provided a useful summary of the authorities dealing with whether medical expenses are "reasonably necessary" as a result of injury as required under section 60 and set out the approach that is to be adopted.

20. Deputy President Roche in *Diab* said as follows:

> "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) 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.'
>
> 77. The Commission has applied this test in several cases (see, for example, *Ajay Fibreglass Industries Pty Ltd t/as Duraplas Industries v Yee* [2012] NSWWCCPD 41 at [67]).
>
> 78. In addition, the Commission has been guided by, and generally followed, the decision of Burke CCJ in *Bartolo v Western Sydney Area Health Service* [1997] NSWCC 1; 14 NSWCCR 233 (*Bartolo*), where his Honour said, at 238D:
>
> > 'The question is should the patient have this treatment or not. If it is better that he have it, then it is necessary and should not be forborne. If in reason it should be said that the patient should not do without this treatment, then it satisfies the test of being reasonably necessary.'
>
> 79. The Arbitrator quoted and applied these statements in the present matter. Subsequent appellate authority suggests that this approach may not be strictly correct.
>
> 80. The Court of Appeal considered the meaning of 'reasonably necessary' in *Clampett v WorkCover Authority (NSW)* (2003) 25 NSWCCR 99 (*Clampett*). That case concerned whether proposed home modifications for a paraplegic were 'reasonably necessary' having regard to the nature of the worker's incapacity. Grove J (Meagher and Santow JJA agreeing) noted that the trial

judge had sought guidance from *Rose* and *Pelama Pty Ltd v Blake* (1988) 4 NSWCCR 264 (*Pelama*), another decision by Burke CCJ where his Honour applied the principles discussed in *Rose* and *Bartolo*.

81. Grove J referred to the dictionary definition of 'necessary' as being 'indispensable, requisite, needful, that cannot be done without' (Shorter Oxford English Dictionary, 3rd ed) and 'that cannot be dispensed with' (Macquarie Dictionary).

82. His Honour added, at [23]–[24]:

> '23. The essential issue is what effect flows from conditioning such qualities as "reasonably". The consequence is to moderate any sense of the absolute which might otherwise be conveyed by the word "necessary" if it stood alone. In order to contemplate such moderation it is apt to consider surrounding circumstances, but the question to be addressed is whether modification of a worker's home, having regard to the nature of the worker's incapacity, is reasonably necessary. In contemplation of what might be "reasonably necessary" there is this statutory obligation specifically to have regard to the nature of the worker's incapacity. It provides emphasis towards moderating the meaning of "necessary" in this context.
>
> 24. The statute does not inhibit inquiry as to what may be thought reasonable in all, or in any particular, circumstances but its terms clearly point to predominant attention being paid to the nature of the worker's incapacity. In my opinion, to reject the appellant's proposal on the basis that expenditure is to be made on premises of which he is a weekly tenant is an elevation rather than a moderation of the meaning of "necessary".'

83. It is important to remember that Grove J's reference in the above passages was in the context of a claim for home modifications under s 59(g). That subsection is restricted to claims for modification of the worker's home or vehicle directed by a medical practitioner 'having regard *to the nature of the worker's incapacity*' (emphasis added). Apart from s 59(f), which deals with care (other than nursing care), there is no such restriction in the other subsections in s 59.

84. In *Wall v Moran Hospitals Pty Ltd t/as Annandale Nursing Home*, Burke CCJ, unreported, Compensation Court of NSW, 30 June 2003, Burke CCJ acknowledged (at [10]) that, contrary to *Rose* and *Pelama*, *Clampett* held that the word 'reasonably' was 'effectively used as a diminutive and moderated the effects of the word "necessary"'.

85. The approach in *Clampett* is consistent with the modern approach to statutory interpretation, which is to construe the language of the statute, not individual words (*Sea Shepherd Australia Limited v Commissioner of Taxation* [2013] FCAFC 68 per Gordon J (Besanko J agreeing)). Thus, 'reasonably necessary' is a composite phrase in which necessity is qualified so that it must be a reasonable necessity (Giles JA (Campbell JA agreeing) in *ING Bank (Australia) Ltd v O'Shea* [2010] NSWCA 71 at [48] (*O'Shea*)). The Court, Bathurst CJ, Beazley and Meagher JJA, followed this approach in *Moorebank Recyclers Pty Ltd v Tanlane Pty Ltd* [2012] NSWCA 445 at [113] (*Moorebank*).

86. Reasonably necessary does not mean 'absolutely necessary' (*Moorebank* at [154]). If something is 'necessary', in the sense of indispensable, it will be 'reasonably necessary'. That is because reasonably necessary is a lesser requirement than 'necessary'. Depending on the circumstances, a range of different treatments may qualify as 'reasonably necessary' and a worker only has to establish that the treatment claimed is one of those treatments. A worker certainly does not have to establish that the treatment is 'reasonable and necessary', which is a significantly more demanding test that many insurers and doctors apply. Dr Bodel and Dr Meakin were both wrong to apply that test.

87. Giles JA added (at [49] in *O'Shea*) that the qualification whereby the necessity must be reasonable calls for an assessment of the necessity having regard to all relevant matters, according to the criteria of reasonableness. His Honour was talking in the context of whether an easement should be granted under s 88K of the *Conveyancing Act* 1919, which provides that 'the Court may make an order imposing an easement over land if the easement is reasonably necessary for the effective use or development of other land that will have the benefit of the easement'. However, his Honour's observations are applicable in the present matter and are clearly consistent with *Clampett*.

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;

    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.

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.

90. While the above matters are 'useful heads for consideration', the 'essential question remains whether the treatment was reasonably necessary' (*Margaroff v Cordon Bleu Cookware Pty Ltd* (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in *Bartolo*, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression 'no reasonable prospect' should be understood, '[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content'."

21. As Deputy President Roche said in *Diab* each case will depend on its own facts.

22. Turning then to an examination of the evidence in this case.

23. Ms Easton gave evidence in a statement dated 3 December 2019.

24. Ms Easton gave evidence that she started full time employment with the Department on 31 October 1994 as an enrolled nurse employed at a Centre which cared for elderly, developmentally and physically disabled patients. She gave evidence that she suffered a number of injuries to her back in that employment prior to her knee injury on 11 October 1997 and she aggravated her back in the subject fall. She suffered ongoing pain and disability in relation to her back injury and has received multiple awards of lump sum compensation in respect of same. She gave evidence that she suffered three injuries to her right knee in that employment in 1997, namely on 5 July 1997, 11 October 1997 (which is the injury the subject of these proceedings) and on 29 December 1997.

25. She gave evidence that she suffered an injury to her right knee on 5 July 1997 as follows:

> "12. On 5.7.1997 I injured my right knee when I stepped out onto the Court yard and misjudged the depth of the step and landed heavily on my right leg at work."

26. She did not give evidence about any sequelae to the injury on 5 July 1997 in terms of treatment or time lost from work.

27. Ms Easton gave evidence about the injury to her right knee on 11 October 1997 (which is the injury relied upon in these proceedings) when she slipped and fell in the female staff toilet. She reported the injury. She was placed on light duties. She saw her GP Dr Petersen after this injury. She had investigation of her knee in the form of an x-ray on 9 January 1998. She gave evidence that her right knee was never the same after this injury and she had always had some pain walking up and down stairs after this injury. She gave evidence that she was on constant strong pain killers as a result of her back injury and she believed that these painkillers masked the symptoms in her right knee. She was not cross- examined about her evidence. She gave evidence as follows:

> "37. On 11.10.1997 I again injured my right knee when I slipped on the floor in the female staff toilet in Unit 10 at about 4.30 am.
>
> 38. The tiles in this area were not of non-slip variety.
>
> 39. I landed on my right knee and aggravated my back.
>
> 40. I reported the injury to BOB COX the RN.
>
> 41. I saw a Dr Mark Peterson at BONNELLS BAY and was placed on selected /light duties.
>
> 42. I was not required to work upstairs.
>
> 43. I was on light duties for a period of time.
>
> 44. I continued having some form of right knee pain after this incident.
>
> 45. On 9.1.1998 I had an x ray of my right knee.
>
> 46. I continued working on light duties.
>
> 47. On 4.5.1998 I saw Dr Peterson and was given a medical certificate to be fit for suitable duties from 16.4.1998 to 3.5.1 998 and to be fit for full duties from 4.5.1998 but was to report any pain or disability.

48. My right knee was never the same after the incident in October 1997.

49. I have always had some pain when walking up and down stairs but my back injury was the main focus of my problems over the next couple of decades.

50. I have been on constant pain killers since then for my back and I believe this has masked my symptoms for my knee."

28. Ms Easton went onto give evidence about an injury to her right knee on 29 December 1997 when loading laundry bags as follows:

> "51. On 29.12.1997 at 5.00 pm, I twisted my right knee at work whilst loading laundry bags onto a trolley in the Laundry. This was witnessed by G Burke and I reported it to her as my supervisor. I experienced swelling of my knee."

29. Ms Easton went onto give evidence that her last day of physical work was 28 August 1998. She was medically retired on 13 October 2000.

30. Ms Easton went onto give evidence about various awards of compensation she has received for her back injury on 30 November 2000 in the Compensation Court (proceedings 58409/1999); in 2005 in the Commission (matter number 13898/2005) and in 2015 in the Commission (Matter number 1192/15). She received payments of lump sum compensation in respect of her back injury. These proceedings were not in relation to her right knee injury.

31. Ms Easton went onto give evidence that by late 2017 her right knee began to cause her more problems and she was referred for MRI investigation as follows:

> "By late 2017 my right knee began causing me greater problems when as part of my attempts to lose weight I tried to become more active.
>
> I saw my GP Dr MORRIS and she referred me to have an MRI scan of my right knee.
>
> On 9.2 .2018, I had an MRI scan on my right knee. I was told that I had an old injury to my right knee."

32. In 2019 Ms Easton brought proceedings in the Commission (matter number 6581/18) in respect of her right knee about which she gives evidence as follows:

> "On 29 March 2019 in WCC Matter No 6581/18, QBE accepted my right knee injury and I was paid weekly compensation for the period 9.10.2 018 to 6.11.2018."

33. Ms Easton went onto give evidence that since the award of compensation on 29 March 2019 her right knee has deteriorated and she has had further MRI investigation and her treating surgeon Dr Verheul has recommended a total right knee replacement. She gave evidence in this regard as follows:

> "Since 29.3.2019 my right knee has deteriorated.
>
> On 8.4.2019 I had an MRI scan of my right knee which showed that I had damage to my meniscus.

I saw Dr VERHUEL who has recommended that I undergo a Total Right Knee replacement at LAKE MACQUARIE PRIVATE HOSPITAL.

He wrote to QBE asking for permission but I was required to see an Orthopaedic surgeon on behalf of QBE before they would decide to pay it or not.

On 12.6.2019, I saw Dr Paul HITCHEN in SYDNEY at the request of Bartier Perry Solicitors.

When I saw Dr HITCHEN he asked me whether or not I had the films of the MRI scan that I had on 8.4.2019.

I advised him that I had not been provided with a copy of them by any of my Doctors.

He didn't ask me to send him a copy of them. I believe if he wanted to, he could have obtained a copy of the MRI scan results from Dr VERHUEL."

34. Ms Easton went on to give evidence as follows:

"On 12.7.2019 I was sent a letter from Bartier Perry Solicitors acting on behalf of QBE advising me that they were denying liability for the Total Right Knee replacement recommended by De VERHUEL. This was called a Section 78 Notice.

The basis for such denial was based on the opinion of Dr HITCHEN in his report dated 14.6.2019.

Dr HITCHEN was not provided with a copy of the MRI report of my right knee from
Dr Lynn SMITH dated 8.4.2019.

This MRI confirmed that I was suffering the following:

- Tear of the lateral meniscus
- Degenerative changes mainly involving the medial joint compartment and also the lateral joint to a lesser extent
- Chondromalacia patella mainly over the lateral facet

Dr HITCHEN provides a diagnosis of "patellofemoral dysfunction and early or mild osteoarthritis ".

In Dr HITCHEN'S report he does not consider that the knee replacement would have " actual or potential effectiveness".

I believe he says this because of my weight issues.

I have been regularly advised by my Doctors to lose weight. One of the activities that has been stressed to me is to WALK.

I have been advised to do this because it will not impact heavily on my back issues.

I cannot walk very far because of the problem with my right knee.

If my right knee is replaced I have been advised that my mobility will increase and I will be ab le to walk farther, thus reducing my weight.

Dr HITCHEN makes a comment that the pathology in the February 2018 MRI becomes " increasingly common from 40 years of age". If this was true I would have similar issues with my left knee.

Since I saw Dr HITCHEN I have reduced my weight by 13 kgs and still have the issues with my right knee and wish to have the operation to replace my right knee."

35. There is no dispute that Ms Easton injured her right knee at work on 11 October 1997, when she slipped on the tiles in the staff toilet and landed heavily on her right knee. Ms Easton reported her injury of 11 October 1997 and sought treatment. There is report dated 16 February 2018 from GP Dr Petersen in evidence, where he reports to the insurer at their request, as follows:

> "In answer to your letter of 15 January 1998 I enclose the following information.
>
> Patient presented to us on 6/1/98 reporting that she had fallen on a tiled floor on 10/10/97 at Morisset Hospital. She sustained an injury to her right knee which had resulted in bruising and since that time her knee had repeated swelling which had now spread down to her ankle. The knee clicked which was consistent with a meniscal injury and she reported pain when getting up from a kneeling position.
> An x-ray of the knee was requested which was normal but that would be not inconsistent with a meniscal injury. At the present stage we made no further arrangements for treatment and the patient has not since returned to us for further treatment. As the knee has recurrent swelling I have arranged for her to work light duties and not to walk more than 300 yards or any lifting over 20kg to see if her swelling is reduced.
>
> The prognosis of her injury is excellent if treated conservatively but if further swelling and clicking remain a problem she will be referred to a orthopaedic specialist for consideration of meniscal excision Her condition is consistent with the cause as she has reported to us. My awareness for her present condition of fitness to her work is described above but she will be reviewed late this month and we will have a good idea then as to her future capacity for work is but it is likely to be quite good."

36. Ms Easton was seen by Dr Anderson, occupational physician, at the request of the insurer and he provided a report to them dated 22 January 2018. He took a consistent history of the injury on 11 October 1997 as follows:

> "On 11.10.97 while on night duty, Miss Easton went to the staff WC. She walked into the area, slipped on the tiled floor and landed with all of her weight on her right knee. (Even then her weight was around 110 kg). There was swelling, bruising and quite a lot of pain of the knee. Gradually, however, the condition seemed to resolve.
>
> Over the last month or so the right knee has again deteriorated with a sensation of rubbing inside the knee and swelling.
>
> She saw her family doctor. She was referred for X-rays and was advised that she could continue working provided she did no heavy lifting and no walking for more than about 300 yards. She is to be reviewed by her family doctor at the end of February."

37. Dr Anderson noted Ms Easton had pain and swelling immediately after injury, some improvement and then a deterioration in that pain. He noted the pain is worse if weight bearing. He noted an intermittent clicking.

38. He noted Ms Easton to be significantly overweight at the time of injury which he noted is a condition she has always had. I note this is consistent with all of the evidence before me and I note that evidence shows Ms Easton to have the condition of obesity since childhood.

39. Dr Anderson conducted a physical examination of which there were positive signs.

40. He reviewed the radiological investigation which was the x-ray of 9 January 1998. Whilst he noted that this was reported as normal, he did note the films showed some abnormality as follows:

> "9.1.98 Plain Xray right knee. In the radiological report this is described as normal. Nevertheless, there appears to be slight narrowing of the medial joint space."

41. Dr Anderson attributed causation to the injury on 11 October 1997. He noted that on his assessment on 22 January 1998 she had "continuing right knee dysfunction and clinical evidence of chondromalacia patellae". As to causation he opined:

> "The injury of 11.10.97 when she fell with virtually all of her weight onto the right knee could reasonably be the precipitating factor for the development of this condition."

42. Dr Anderson considered Ms Easton to be well motivated towards her occupation but less so towards her own physical condition. He noted her to be "enormously overweight and apparently has always been in this category".

43. Dr Anderson considered the prognosis to be reasonable but not necessarily good noting the condition could continue for a protracted period of time. He opined as follows:

> "Prognosis.
> This is reasonable, although not necessarily all that good. This condition can continue on for a protracted period of time. With the additional issues identified, particular her excess weight, it is likely to continue on for a longer, rather than a shorter period of time."

44. Dr Anderson provided the following summary:

> "Ms Easton fell directly onto her right knee in mid-October 1997. She subsequently developed chrondomalacia patellae, although this did not seem to come on until several months later.
>
> The issue is confounded by her enormous excess weight."

45. There is no doubt on the evidence that Ms Easton was overweight at the time of injury. She had been overweight since childhood. She remains overweight. She has lost some weight (about 13 kgs) and her evidence is that she cannot exercise to lose more weight because of the pain and restriction in her right knee. This is part of the reason why she wants to have the surgery. She was not cross-examined about her evidence.

46. Ms Easton saw her treating GP Dr Morris because of her ongoing problems with her right knee. She was referred for MRI investigation and on 9 February 2018 Ms Easton had a MRI. The MRI noted a clinical history of "?Acute meniscal tear. Inability to extend right knee fully". The findings were summarised as follows:

> "Oedema to fibular head ?microtrabecular injury. Thickening of the fibular collateral ligament suggestive of an old injury. In addition, the lateral meniscus is mildly extruded on a background of moderate lateral joint space OA. There is also a small focus chondromalacia patella as described."

47. Following the findings on the MRI dated 9 February 2018, Dr Morris referred Ms Easton to Dr Verheul, orthopaedic surgeon. The referral was made by the GP on 5 March 2018 (noting Dr Verheul was not able to see Ms Easton until 5 June 2018) in the following terms:

> "Thank you for seeing Kylie, aged 44, for your review. Kylie has chronic R knee injury, injured over 20 years ago. Slipped on wet floor at work, fell directly onto that knee.
>
> She had XR at the time & was on light duties for few weeks (Workers Compensation). She has just felt the pain getting worse in the last few months. It effects everything she does. She says she can just fall over at any given moment. Worse getting upstairs.
>
> I would be grateful for your assessment, opinion and management advice."

48. On 5 June 2018, Dr Verheul reported back to the GP Dr Morris as follows:

> "Thanks for the referral of Kylie Easton. She is a 45 year old lady with problems referable to her right knee.
>
> She first injured this knee about 20 years ago when she slipped on a wet floor and landed heavily on her right knee, injuring it and her lower back. She has had ongoing symptoms since that time and limited mobility. She has had no operations or injections relating to that knee.
>
> She is now suffering with intermittent falls and pain, which isn't really controlled with Celebrex and Panadol. She is on Lyrica for her spine. I take note of the fact that she is on Metforrnin and Diamicron for her non-insulin dependent diabetes and Citalopram for depression. She hasn't worked for years due to her injuries.
>
> On physical examination Kylie's knee is still in reasonable alignment with a range of motion at 0-140°. She is tender on both her joint lines. She has significant patellofemoral crepitus. Her hips rotate freely. Her MRI was not available for review, but suggests a lateral meniscal tear and a moderate degree of osteoarthritis.
>
> My belief is that Kylie's current problem does date back to her original work place injury and that is when it started her problems and they have been ongoing and deteriorating since that time. She probably sustained a lateral meniscal tear at that time and due to the loss of that meniscus, has developed arthritis in the lateral compartment of her knee. If it is a moderate degree of osteoarthritis, then I would be suggesting a hyaluronic acid injection to her knee in an effort to improve her symptoms and then failing this, PRP.
>
> Otherwise, I think she should be nursed along as best as possible, until total knee replacement surgery is warranted."

49. I note that Dr Verheul did forecast that ultimately a knee replacement would be needed although at this stage he was recommending conservative measure be undertaken in the form of hyaluronic acid injection and failing that PRP. These conservative measures were not undertaken and, in the Department's submission, this should be fatal to Ms Easton's case.

50. On 9 October 2018, Dr Verheul provided a report to Ms Easton's lawyers at their request as follows:

> "Here is a report as requested in regard Kylie Easton.
>
> My records indicate that Kylie had a fall approximately 20 years ago, which was dated as the 27th December 1996, when she slipped on a wet floor and landed heavily on her right knee, injuring it and her lower back.
>
> She has had ongoing symptoms relating to her right knee since that time. She had no pre fall problems. Since that time, she has had no operations or injections relating to that knee. She was seen by a G.P and subsequently by the independent medical examiner for GIO. She continued to work on selected duties, but never regained normal function of her knee.
>
> Over the course of time it has deteriorated and it is now precipitating instability, manifested as falls and pain. She continues on with Celebrex and Panadol for it and she is also on Lyrica for her spine.
>
> Her MRI was not available for review on the day that I saw her, which was the 5th June 2018. I was subsequently able to review the films myself and her MRI demonstrated osteoarthritis of the patellofemoral articulation. I believe that the remainder of her knee was in quite reasonable condition.
>
> As a result of the MRI evaluation and the history obtained, I think the first situation would be to provide Kylie with a hyaluronic acid injection to her knee.
>
> I do believe that the injury she sustained is as a direct result from the injury sustained in the course of her employment, as she has no symptoms relating to her contralateral knee and the isolated lesion in the lateral facet of her patella is consistent with an impaction type injury.
>
> I believe that she is currently unfit for work due to the instability and pain relating to her knee."

51. Ms Easton was referred for a repeat MRI which was undertaken on 8 April 2019 and reported on as follows:

> "Clinical History: Injury 20 years ago. Lateral meniscal tear. Developing OA. For review.
>
> MRI Right Knee
>
> Standard sequences have been performed. Comparison is made with the previous MRI from February 2018.
>
> There is a small joint effusion. The anterior and posterior cruciate ligaments are intact with no anterior tibial translation.
>
> Intact medial meniscus. There is a tear of the lateral meniscus mainly involving the posterior horn and body.
>
> There is diffuse thinning of the articular cartilage over the medial femoral condyle and to a lesser extent the medial tibial plateau. There is also cartilage loss over the weight bearing surf ace of the lateral femoral condyle which has progressed since the previous study. No subarticular cystic change.

Intact medial and lateral collateral ligaments. Intact popliteus tendon and biceps femoris attachment.

The anterior extensor mechanism is intact. There are signal changes in the articular cartilage over the latera l facet of the patella with subtle subarticular cystic change. The trochlear cartilage is maintained. Similar appearances to the previous study.

The retlnacula are Intact. No Baker's cyst. There is no longer bone marrow oedema in relation to the proximal fibula.

Conclusion

There is a tear of the lateral meniscus.

Degenerative changes mainly involving the medial joint compartment and also at the lateral joint to a lesser extent.

Chondromalacia patella mainly over the lateral facet. Stable appearances."

52. With the benefit of the repeat MRI, Dr Verheul reported back to the GP by letter dated 29 April 2019. He considers that the time for non-operative intervention has now passed and that conservative measures would not assist. He wrote as follows:

> "I have just reviewed Kylie Easton who has had her MRI repeated. It certainly does demonstrate osteoarthritis of the medial compartment of her knee, more of a meniscal tearing in the lateral compartment and osteoarthritis once again of her patellofemoral.
>
> Given Kylie's young age of 45 years, I do believe that the precipitating event to all of this were the injuries she sustained when she landed on her knee, approximately 20 years ago.
>
> Given that she never improved after this fall and her symptoms have been deteriorating over the course of time, there is a relationship to it. It has been the causative factor to her knee, as well as the premature need now for total knee replacement surgery.
>
> I don't believe any other non-operative measures are going to be of any benefit to her, including arthroscopy, hyaluronic acid injections. physiotherapy or PRP. She is now at the point where she lives with her symptoms, or undergoes knee replacement surgery.
>
> We have discussed the nature and outcomes of this and we will book her right knee replacement for the 20th June at Lake Macquarie Private Hospital and seek approval from the insurers to this effect."

53. The operation proposed for June 2019 did not take place in view of the denial of liability.

54. On 28 October 2019, Dr Verheul provided a report to Ms Easton's lawyers at their request. Dr Verheul commented on the report of Dr Hitchen, the IME qualified on behalf of the insurer, as follows:

> "Thanks for requesting a report in regard to Kylie Easton.
>
> I have read the report from Dr Paul Hitchen and I have a number of controversies related to it.

First of all, I think if someone is giving an independent medical report and is an experienced Orthopaedic Surgeon, then they should visualise the films to make their own interpretation of it. The MRI taken on the 9th February 2018, does indicate a lateral meniscal tear that extends to the articular surface and, as such, does constitute a lateral meniscal tear (as opposed to the report). This is viewed on the sagittal PDFS films.

I agree that she has substantial osteoarthritis on that side.

Given that the meniscal tear extends to the articular surface, this is certainly a predisposition to lateral compartment osteoarthritis and we know that this is the case, based on the literature, in that both the femoral and tibial articular surfaces are convex in shape and in the lack of appropriate meniscal function, precipitates osteoarthritis.

There is no doubt that her morbid obesity has contributed to this, but the underlying foundational problem is the lateral meniscal tear.

Neither of her body mass index or age contraindicate total knee replacement surgery, although the risks associated with the procedure under this situation are dramatically different. We do know that people with a body mass index greater than 40, are at significant increased risk of infection and that this becomes increasingly difficult to deal with, however this is a matter of counselling the patient in regard to that and allowing them to make their own decision.

In regard to total knee replacement surgery for someone of Kylie's age, once again it comes down to counselling in regard to explaining to them the limited life span of a knee replacement in this situation .

Nonetheless, decision in regard to proceed or not to proceed with total knee replacement surgery, is determination of their pain and function and loss of expiration of other non-surgical options.

Finally, lateral meniscal tears and osteoarthritis typically present as episodes of instability, as opposed to medial compartment osteoarthritis, which is more of an activity related ongoing pain.

I have further read through. Dr Paul Hitchen's report and he indicates that the arthritis is early or mild at best. This is in his discussion Point 3. The films indicate moderate to severe arthritis.

Once again, thanks for the request of the report and if there is any further information I can provide, please don't hesitate to contact me."

55. Professor Ghabrial, orthopaedic surgeon, is the IME qualified on behalf of Ms Easton.

56. Professor Ghabrial saw Ms Easton on 30 October 2019 at the request of her lawyers and provided a report to them of the same date as follows:

"Thank you for your letter dated the 30th October 2019 requesting a medical report for Mrs. Easton who attended my clinic on the 30th October 2019 for the purpose of examination and submitting the following medical report.

Mrs. Easton gave me the history of multiple injuries to her right knee during her employment as follows:

5th July 1997 when she misjudged the depth of a step and landed heavily on her right knee.

11th October 1997 when she was walking into the female staff toilets and slipped on the tiles landing heavily on her right knee.

29th December 1997 when she was loading laundry bags into the trolley and twisted her right knee experiencing severe pain to her right knee.

I understood that she had x-rays at the time and she was not subjected to any treatment apart from medications for pain relief.

Her symptoms over the years continued to deteriorate. I understood that she stopped working towards the end of 2014 however she has not been involved in any employment since then.

She continued to deteriorate and she saw her local medical officer, Dr Joanne Morris in early 2018. Dr Morris referred her for an MRI scan of the right knee on the 9th February 2018 and following that she was referred to Dr Richard Verheul. She had further MRI scanning on the 8 April 2019. Initially he suggested arthroscopic debridement and injections and physiotherapy treatment.

Dr Verheul recommended right total knee replacement because of the marked osteoarthritis of the right knee and she was booked for a left total knee replacement on the 20th June 2019 but unfortunately her insurer denied liability and she has not had this done as yet as she does not have any private insurance and Dr Verheul does not work in the public system.

She reported that her right knee continued to deteriorate and she is finding it difficult to walk.

Examination of the right knee on the 30th October 2019 showed no scars or deformity. There was moderate swelling and effusion and there was mild quadriceps muscle wasting. There was marked tenderness on the antero-lateral aspect of the right knee. The range of motion was 0° - 110°. The ligaments were normal. There was moderate pain in the patella-femoral joint. The sensation, flexion power and extension power were normal.

The MRI scan performed to the right knee on the 9th February 2018 showed oedema of the fibula head with moderate osteoarthritic changes in the right knee with a tear of the lateral meniscus.

The MRI scan performed to the right knee on the 8th April 2019 showed deterioration of the osteoarthritic changes as well as the tear in the lateral meniscus. There was evidence of osteoarthritic changes as well in the patella-femoral compartment.

The recent x-rays of the right knee performed on the 30th October 2019 showed moderate osteoarthritic changes of the right knee and patella-femoral joint measuring 2mm cartilage interval in both joints.

OPINION:

Mrs. Easton sustained multiple injuries to the right knee in July, October and December 1997.

Clinical assessment and investigations suggested a tom lateral meniscus as well as the development of osteoarthritic changes in the knee joint as well as the patella-femoral joint.

It is highly likely that she will continue with her present disabilities and she remains unfit for activities involving any running, climbing ladders, going up and down stairs excessively, walking on uneven grounds, standing for lengthy periods, walking for long distances, kneeling and squatting.

I believe that ultimately she will require right total knee replacement as suggested by Dr Verheul.

From the history given to me by Mrs. Easton, I believe that her employment is considered to be the main contributing factor to the present clinical features, disabilities and impairment.

I believe that her condition has stabilised for the purpose of assessment of permanent impairment."

57. Professor Ghabrial provided a report to her lawyers dated 12 February 2020 wherein he opines that Ms Easton's weight or age is not a contraindication for the total knee replacement surgery. This is consistent with the treating surgeon's opinion. Professor Ghabrial opines as follows:

"Thank you for your letter requesting a medical report for Mrs Easton.

I believe that she will require right total knee replacement, as suggested by Dr Richard Verheul, Senior Consultant Orthopaedic Surgeon.

I believe that her condition, under these circumstances, has not stabilised.

I believe that her body mass index or age does not contra-indicate right total knee replacement."

58. Dr Hitchen is the IME qualified on behalf of the Department. Dr Hitchen saw Ms Easton on 12 June 2019 and provided a report dated 14 June 2019 to the Department's lawyers.

59. Dr Hitchen recorded a history as follows:

"Mrs Easton claims an injury to her right knee for which her treating surgeon, Dr Verheul, has recommended proceeding to right knee replacement.

She had been employed as an Enrolled Nurse at the Kanangra Centre from 1994 until about 1997.

On 11 October 1997, she fell in a toilet cubicle on a wet floor. She believes that as she fell she fell onto the anterior aspect of her right knee. Her recollection is that she was able to get herself up and move around. She did recall seeing her General Practitioner, Dr Peterson. She believes an x-ray was undertaken and she was told that one day her right knee condition might come against her. Nevertheless, no specific orthopaedic referral was made for treatment on her knee.

In the years that followed, she states that from time to time her left or right knee would spontaneously collapse on her and she attributed this to back pain. In particular, she believes a few times she fell directly onto the front of her right knee. She states she began to get increasing right knee pain from about 2018 onwards. She eventually saw her GP. She recalled having an x-ray and MRI undertaken. She was referred to Dr Verheul, Orthopaedic Surgeon. It was suggested to her that she could potentially consider some injections into the right knee but initially she did not follow through with it. I understand her right knee pain worsened in early 2019, and she had a further MRI. From there she was told by her surgeon that injections would not be beneficial, and that she should proceed to a knee replacement. She is hopeful of having a knee replacement shortly pending workers' compensation approval.

At this point in time, she states she has diffuse pain in the right knee but particularly anteriorly and medially. Her pain worsens after walking on the flat for more than 10 minutes. She avoids stairs and inclines as much as possible. She has a sensation that her knee might swell. She has not had any physiotherapy. She takes Celebrex for her knee symptoms. She states her left knee is relatively pain free.

In the last six months her weight has decreased from 125kg to 110kg. She stands at 158cm. (current BMI = 44; morbid obesity). As such, she has been significantly overweight for many years.

Mrs Easton states she has a number of health problems including Type II diabetes, anxiety and depression and chronic lower back pain."

60. Dr Hitchen conducted a physical examination of which he recorded as follows:

> "Mrs Easton was pleasant and co-operative. She was of a large build. She walked with a slight limp.
>
> Examination of both knees was similar. When seated there was chronic lateral patella maltracking evident with the patella only centralising at about 40° of knee flexion bilaterally. There was bilateral discomfort and mild crepitus evident on palpation over the patellofemoral joint.
>
> On the right side, I was unable to detect an effusion. There was a range of motion from 0° to 120° of flexion. There was general tenderness over the medial and patellofemoral region and to a lesser extent the lateral compartment. The collaterals and cruciate ligaments were stable."

61. In respect of a review of the radiological investigations, Dr Hitchen noted he did not have access to the actual films, nor the 2019 MRI report. He commented on the MRI report of 9 February 2018 (not the film) as follows:

> "She did not have any films, so I rely upon the report obtained. I note the 2019 MRI report is not available. My comments are italicised.
>
> A MRI of the right knee from 9 February 2018 reports the lateral meniscus has high signal, but this does not reach the joint surface (*and as such this does not fulfil the criteria of a meniscal tear*). The meniscus is said to have mild extrusion (*as is commonly seen with arthritis*). There is Grade IV (*bare bone or osteoarthritic change*) of the lateral patella facet and moderate articular cartilage wear of the lateral and to lesser extent medial compartments."

62. Dr Hitchen then proceeded to answer a series of specific questions as follows:

"Diagnosis and causation

1. *Please obtain a history from the worker, including:*

(a) *Her current symptoms*

Activity related right knee pain which is fairly diffuse and in particular patello-femoral.

(b) *Her current employment, domestic, social and recreational activities*

She is presently on the disability support pension. She has no physical activities. Her recreational pursuits are knitting and listening to music. At home, she has help with her house duties.

(c) *Any treatment she is currently undertaking*

For her knee symptoms she is taking Celebrex. She is otherwise on Lyrica for her chronic back and radicular pain.

(d) *Any prior or subsequent injuries she has sustained*

She denies any previous injury to her right knee. Over the years she states she has been prone to falling as her legs spontaneously give way on her and on some occasions she has fallen directly onto both knees.

2. *Please outline your findings on examination.*

See body of report. Her physical findings are consistent with chronic bilateral patello- femoral maltracking – predisposing her patellofemoral arthritis. Clinically, she also has a mild degree of medial and lateral compartment arthritis.

3. *What is your diagnosis of the worker's injury?*

Patellofemoral dysfunction and early or mild osteoarthritis.

Incapacity

4. *Do you believe the worker is incapacitated for work from an orthopaedic perspective? If so, why and to what extent?*

With respect to her knees, she is incapacitated to undertake work that involves repetitious squatting, crouching or kneeling. Otherwise, with respect to her knees, she could work full-time.

5. *If you believe the worker is fit to work, could you please indicate what sorts of jobs she could reasonably carry out having regard to all of the circumstances, including for how many hours/days per week and whether there are any restrictions applicable.*

With respect to her knees, she could reasonably carry out sedentary or light sales work. For example, full-time office duties or retail sales is reasonable. Her restrictions would be to avoid repetitious squatting, crouching or kneeling or not to stand in excess of one hour without a five minute seated rest break. This is to take into account her right patellofemoral dysfunction and mild arthritis.
Medical expenses

6. *What medical treatment has the worker had to date? Has it been reasonably necessary? If not, why not?*

Treatment so far has recently involved review with Dr Verheul, Orthopaedic Surgeon. His correspondence from June 5 2018 postulates the original fall caused a lateral meniscal tear. He then suggests this resulted in lateral compartment arthritis. I disagree on a number of points. Firstly if she had a direct fall in a confined space onto the front of the knee, the mechanism is unlikely to tear a lateral meniscus. Secondly she did not have her knee examined by an expert orthopaedic surgeon within a short period after the fall to ascertain where her pain might be coming from. Thirdly the 2018 MRI does not report a meniscal tear. Fourthly, we know that meniscal signal change becomes increasingly common with age from 40s onward, and that extrusion is a common finding with arthritis in the relevant compartment.

For these reasons I do not believe Dr Verhuel's argument is plausible in the context of injury. His letter of 5 June 2018 does not mention the role of obesity in joint deterioration. Further she is predisposed to knee arthritis due to clinically apparent patellofemoral maltracking. Over her lifetime this will unevenly wear the retropatellar surface. The risks of patellofemoral degeneration increase substantially with increased body habitus. She has been substantially overweight for many years.
It follows that in my opinion ongoing treatment with an orthopaedic surgeon on the basis she sustained a meniscal tear precipitating osteoarthritis is not reasonably necessary.

Do you consider the worker requires any further medical treatment? If so, please indicate what you think might be a reasonable treatment regime, the period of time over which it would be provided and details of how it might improve her condition. If not, why not?

Dr Verhuel has recommended a right knee replacement. On the face of it, I do not believe knee replacement could be construed as reasonably necessary.

The main medical treatment would be weight reduction, as this will help unburden her weight bearing joints. It may well take many months if not years to do so. It will not be a complete cure however as her patella maltracking will always remain (constitutional) and a lifetime of damage has accumulated.

I would recommend against knee replacement until she has significantly reduced her body mass index given the high risk of complications including premature wear and infection. Further, given her relatively young age of 46, this should be stalled for as long as possible as a knee replacement will only last approximately 20 years."

63. Counsel for the Department made submissions that Ms Easton relies only on the injury of 11 October 2020 in respect of her claim for surgery and that, in accordance with Dr Hitchen's opinion, a meniscal tear is unlikely to have resulted from the mechanism of injury being a direct fall. Counsel for the Department went onto submit that a meniscal tear is more likely to have resulted from the subsequent injury on 29 December 1997 when she twisted her knee carrying the laundry bags. He said that the opinion of Dr Petersen, the GP who saw her back in January 1998 cannot be relied upon because he didn't have a history of the later injury. However, there is no medical evidence before me in this case to support that the lateral meniscal tear is more likely to have resulted from a twisting injury or the subsequent injury on 29 December 1997. I cannot conclude that a meniscal tear is more likely to have resulted from a twisting injury in December 1997 than the fall on 11 October 1997 because there is no medical evidence that says that. Dr Hitchens says in his opinion the lateral meniscus tear is unlikely to have resulted from a direct fall. He doesn't say that it is more likely to have come from a twisting injury or the later injury. Dr Verheul says that the lateral meniscal tear has resulted from the subject fall in the wet toilet cubicle and that tear has contributed to the development of moderate to severe osteoarthrosis in the right knee, with the underlying foundational problem being the lateral meniscal tear. The medical opinions must be weighed in the balance with all of the evidence to reach a determination on the balance of probabilities whether the proposed surgery is reasonably necessary as a result of the injury on 11 October 1997.

64. I note that that Dr Hitchen did not have the benefit of the actual films of the MRI investigations nor did he have the 2019 MRI report. This was raised as an issue at the telephone conference and arrangements were made for the films to be given urgently to the Departments' solicitor for their urgent production to Dr Hitchen. The Department filed a late document on 23 April 2020 which was admitted by consent. In that late document it is very clear that the solicitor for the Department attempted to get Dr Hitchen to look at the film of the MRI dated 8 April 2019 (contained on a CD). Dr Hitchen, in no uncertain terms, stated (which is recorded in an email dated 22 April 2020) as follows:

> "looking at the CD is not going to change my opinion they need to read my last report again carefully as I have clearly stated I do not need to see it".

65. I note that Dr Verheul addresses in his report dated 28 October 2019 why viewing the actual film of the MRI, as opposed to just the report, is important. He says:

> "I have read the report from Dr Paul Hitchen and I have a number of controversies related to it.
>
> First of all, I think if someone is giving an independent medical report and is an experienced Orthopaedic Surgeon, then they should visualise the films to make their own interpretation of it. The MRI taken on the 9th February 2018, does indicate a lateral meniscal tear that extends to the articular surface and, as such, does constitute a lateral meniscal tear (as opposed to the report). This is viewed on the sagittal PDFS films.
>
> I agree that she has substantial osteoarthritis on that side.
>
> Given that the meniscal tear extends to the articular surface, this is certainly a predisposition to lateral compartment osteoarthritis and we know that this is the case, based on the literature, in that both the femoral and tibial articular surfaces are convex in shape and in the lack of appropriate meniscal function, precipitates osteoarthritis.

> There is no doubt that her morbid obesity has contributed to this, but the underlying foundational problem is the lateral meniscal tear.
>
> …
>
> Finally, lateral meniscal tears and osteoarthritis typically present as episodes of instability, as opposed to medial compartment osteoarthritis, which is more of an activity related ongoing pain.
>
> I have further read through. Dr Paul Hitchen's report and he indicates that the arthritis is early or mild at best. This is in his discussion Point 3. The films indicate moderate to severe arthritis."

66. Counsel for the Department submitted that conservative options have not been exhausted or indeed undertaken and this would be necessary before I could find that the proposed surgery is reasonably necessary as a result of the injury. Counsel for the Department also pointed to the risks involved with the surgery because of Ms Easton's weight. Counsel for the Department also pointed to the young age of Ms Easton compared to the lifespan of a knee replacement.

67. It is clear that Dr Verheul, the treating surgeon, has taken the risks associated with surgery and Ms Easton's weight into account as well as the lifespan of a knee replacement. He says in his report dated 28 October 2019 as follows:

> "Neither of her body mass index or age contraindicate total knee replacement surgery, although the risks associated with the procedure under this situation are dramatically different. We do know that people with a body mass index greater than 40, are at significant increased risk of infection and that this becomes increasingly difficult to deal with, however this is a matter of counselling the patient in regard to that and allowing them to make their own decision.
>
> In regard to total knee replacement surgery for someone of Kylie's age, once again it comes down to counselling in regard to explaining to them the limited life span of a knee replacement in this situation.
>
> Nonetheless, decision in regard to proceed or not to proceed with total knee replacement surgery, is determination of their pain and function and loss of expiration of other non-surgical options."

68. Professor Ghabrial in his report dated 12 February 2020 opined that Ms Easton's "body mass index or age does not contra-indicate right total knee replacement."

69. As Deputy President Roche set out in *Diab*, each case depends on its own facts. Each case will be decided on the balance of probabilities on the evidence in the case. As Deputy President Roche said in *Diab* whilst the checklist of relevant matters according to the criteria of reasonableness is helpful, it is not determinative nor exhaustive. The question for determination in this case is whether the proposed treatment in the form of a right total knee replacement, after weighing all of the evidence in the balance, is reasonably necessary as a result of injury on 11 October 1997. As the Deputy President said:

> "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;

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.

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.

While the above matters are 'useful heads for consideration', the 'essential question remains whether the treatment was reasonably necessary' (*Margaroff v Cordon Bleu Cookware Pty Ltd* (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in *Bartolo*, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression 'no reasonable prospect' should be understood, '[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content'."

70. When I weigh all of the evidence in the balance, I prefer the evidence given by Ms Easton, unchallenged by cross-examination, of the ongoing problems with her right knee since injury on 11 October 1997 and why she wants the surgery and I prefer the opinion of Dr Verheul to that of Dr Hitchen. Dr Verheul has had the benefit of reviewing the film of the MRI of 2019 and provides a diagnosis consistent with history of a lateral meniscal tear in the original injury which has contributed to the development of moderate to severe osteoarthritis in the right knee, with the underlying foundational problem being the lateral meniscal tear from the fall in the wet toilet cubicle. Even though the original x-ray of the right knee on 9 January 1998 was reported as normal, Dr Anderson IME for the insurer who provided a report dated 22 January 1998 noted on viewing the film that there was "slight narrowing of the medial joint space". Dr Petersen, Ms Easton's GP at the time said in his report to the insurer on 16 February 2018 that a normal x-ray "would be not inconsistent with a meniscal injury".

71. Dr Hitchen says the condition is a constitutional one, increasingly common after the age of 40. There is no evidence that Ms Easton is troubled by left knee pain and she gives evidence that she does not have the same problems of pain and restriction with her uninjured left knee.

72. Ms Easton has not tried conservative measures such as acid injections or PRP or hydrotherapy. She does avoid activities which aggravate her knee. She does not work. She takes pain medication. She has tried to lose weight and indeed has lost weight (some 13 kgs). While Dr Hitchen notes that Ms Easton has not undertaken the injections or other therapy, he does not recommend any other conservative measures other than weight loss. Ms Easton gives evidence that she has tried to lose weight and has indeed lost weight but her ability to lose more weight by exercise is constrained by the functional limitations of her right knee, including pain and episodes of instability. It must be borne in mind that Ms Easton has had the condition of obesity since childhood. In Dr Verheul's opinion the time for conservative measures has passed.

73. When I weigh all of the evidence in the balance I am satisfied, on the balance of probabilities, that the surgery proposed by Dr Verheul in the form of a right total knee replacement is reasonably necessary as a result of injury on 11 October 1997. Accordingly, I will make an award in favour of Ms Easton.

74. In the event Ms Easton was successful, the parties agree that orders would be made as follows:

    (a) Award for the Applicant in respect of the surgery in the form of a right total knee replacement as proposed by Dr Verheul on production of accounts and/or receipts.

    (b) The Respondent pay the Applicant's section 60 expenses in the sum of $148 on production of accounts and/or receipts.