Neutral Citation Number: [2020] EWHC 2902 (QB)

Case No: QB-2017-000082

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 02/11/2020

Before :

THE HONOURABLE MRS JUSTICE STACEY

- -

Between :

Betty Plant (by her Son and Litigation Friend, Rodney Winchester	**Claimant**
- and -	
Mr Ahmed El-Amir (1)	**Defendant**
London Eye Hospital Limited (2)	

- -
- -

Ms Samantha Presland (instructed by Ashtons solicitors) for the **Claimant**
Mr Anthony Speaight QC and Mr Marc Beaumont (instructed by the **Defendant under the Bar Direct Access Scheme**)

Hearing dates: 12-15 October 2020

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

Covid-19 Protocol: This judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to Bailii. The date and time for hand-down is deemed to be Monday 2nd November 2020 at 10.30am.

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MRS JUSTICE STACEY

The Honourable Mrs Justice Stacey:

1. This case comes before the court on the claimant's claim of negligence against the first defendant, Mr Ahmed El-Amir, and the second defendant the London Eye Hospital Limited (LEH) in respect of private surgery performed to the claimant's right eye by the first defendant at the second defendant hospital on 23 August 2013 to insert an intraocular lens visual implant, the IOL-VIP Revolution.

2. LEH is now in administration. The claimant had obtained the permission of the administrators of LEH to continue with the proceedings against the hospital pursuant to paragraph 42 of Schedule B1 to the Insolvency Act 1986 and with no objection from the first defendant, an order was made pursuant to Paragraph 43(6) that the matter may continue against LEH in light of that permission. Beyond serving a defence to the claim, the administrators took no part in the proceedings. The claimant however withdrew her claim against LEH at the end of the hearing. There was no objection by the first defendant and accordingly the claim against the second defendant is dismissed upon withdrawal.

3. It was clarified at the outset of the hearing that the claimant was no longer pursuing a claim for breach of a contractual duty of care. Breach of the tortious duty, causation and quantum were all in dispute. It was agreed that the hearing would proceed on liability only, with remedy to be determined, if necessary, in due course.

4. The 9 particular allegations of negligence that were pursued at trial (allegations 25(h) and 25(k)) was abandoned at the outset) fell into two distinct strands: firstly a failure properly or adequately to obtain the informed consent of the claimant for the surgery and to perform the surgery without such consent (allegations at paragraph 25(a)-(g) and secondly the failure to diagnose and treat in a timely manner the claimant's raised intra ocular pressure (IOP) and glaucoma between 25 September 2013 (as pleaded) and 13 December 2013 said to have caused significant, permanent and irreversible damage to her right eye. It was not said that the surgery itself had been performed negligently, but the claimant's challenge was to the fact that the surgery was performed at all.

5. Ultimately, this is a case that turns on its facts. The issues crystallised during the course of the hearing and there were no controversial areas of law.

The evidence

6. The lay evidence comprised witness statements from the claimant dated 7 December 2015, 26 February 2016 and 21 May 2017; from her son Rodney Winchester dated 24 September 2019 and daughter Deborah Ozturk dated 20 September 2019, all of whom gave evidence by video link as had been agreed by both parties. The evidence of the claimant's former partner, Bryan Gifford, dated 26 February 2016 who is sadly now deceased, was served under a Civil Evidence Act 1995 notice.

7. The first defendant's evidence in chief was set out in his written statement dated 5 June 2020 and he gave live evidence at trial. His witness, Mohammed Abu-Bakra did not attend court. The Civil Evidence Act 1995 s.2 notice served on 13 October 2020 said that he was uncontactable but by 14 October he had been traced, but was busy

with professional commitments and the claimant did not oppose his evidence being tendered as hearsay with the usual warnings as to its weight.

8. The expert evidence came from consultant ophthalmic surgeons Mr Robert Morris, MRCP FRCS FRCOphth for the claimant and Professor Claude Claoué, MD, DO, FRCS(Eng) FRCOphth for the first defendant. Mr Morris had prepared two reports, both dated 30 October 2019, on liability and condition and prognosis respectively. Prof Claoué's report was dated 25 June 2020 and he had prepared a supplementary report of 22 July 2020. The joint experts' statement was dated 1 September 2020.

Heading housekeeping and procedural issues

9. A number of documents were added to the bundle by consent during the course of the hearing. There was a dispute as to the accuracy of some of the medical record documents received from the second defendant which the first defendant suggested had been altered. It became an increasingly concerning point for him during the hearing and it was arranged for the original documents to be couriered from the administrators' office in Peterborough to the court so that he could inspect and compare them with the various photocopies provided on various occasions.

10. I am grateful to both counsel for their assistance throughout the trial and for the work of their respective legal teams in their preparation of the documents and bundles.

Findings of fact

11. I make my findings of fact on the balance of probabilities and bearing in mind that it is for the claimant to prove her case. I am grateful to Mr Speaight's useful reminder of the importance of the observations of Leggatt J (as he then was) in *Gestmin SGPS S.A. v Credit Suisse (UK) & anor* [2013] EWHC 3560 (Comm) of the fallibility of human memory and the care to be approached with evidence based on recollection (see paras 15-22). I have considered the contemporaneous documentary evidence (such as it is) alongside the more recently compiled documentation and the oral evidence and been cognisant of the dates of the various statements and letters in the overall chronology of the case.

12. I accept that the claimant's recollection is significantly impaired and that she is no longer able to remember what happened in 2013 and thereafter. After his attempt to cross-examine her, Mr Speaight agreed with the claimant's GP's diagnosis that she suffers from dementia and memory loss and that she was genuinely unable to remember material facts and events. I have borne in mind that Mr Speaight was not therefore able to cross-examine her and in particular was unable to put to her the apparent discrepancies on the state of her eyesight prior to the operation as set out in her medical records and the evidence in her statements. Nor was he able to cross examine her on the consenting process when she attended the hospital for her operation and beforehand.

13. The claimant was born on 30 March 1934. Before her retirement she had worked as a psychiatric nurse for approximately 10 years. She led a busy and full life up until and all through her seventies and was and still is determined to make the most of life. She commenced a relationship with Mr Gifford in around 2010 who described her as having a zest for life. She was remarkably independent and energetic with a great

many interests and hobbies and she was sociable and outgoing. She and Mr Gifford, who was three years her junior, enjoyed many holidays and cruises together. Her eyesight however was deteriorating, but she was otherwise fit, well, healthy (apart from hearing problems) and very energetic for her age. Her two children gave a similar account of her independence and spirit and her spark and determination was still apparent when she gave evidence over the videolink. She was very game, in spite of her limited understanding of what was going on.

14. The contemporaneous medical records, which I find are accurate, note that age related macular generation (AMD) was first detected by her opticians in 1997, especially in the left eye and that by February 2013 the opticians recorded that her right eye, which was still her better eye, had a corrected visual acuity of 2/60 and the visual acuity in her left eye was of hand movements only. She attended the NHS Fakenham Medical Centre in April 2013 on a referral to the low visual awareness (LVA) clinic who recorded that her right eye visual acuity with spectacles was 4/36. The dry AMD diagnosis was confirmed. At a subsequent appointment in May the visual aids that she had been given the previous month had enabled her to read, but slowly and she was unhappy with the size of the magnifying glass that she had been given to help her read. She was advised to sit closer to the television to see better. There was an apparently inconclusive discussion about the possibility of IOL-VIP and the practitioner appears to have offered to try to find out some more information, but there is no record of this being followed up by the clinic.

15. The evidence of the claimant and Mr Gifford was that she was able to use the computer, follow Facebook, watch television, cook and be totally independent although she had stopped driving, which I accepted as accurate. It was consistent with her determination to live life to the full and overcome her eyesight difficulties. She could not however read magazines which was a considerable frustration and disappointment to her. I accept that her evidence that she could see perfectly well out of her right eye is an exaggeration, but only a slight exaggeration as she had successfully developed coping mechanisms to use her peripheral vision as much as possible to mitigate the effect of the AMD to her central vision and that she had adapted her life to manage her deteriorating eyesight as best she could.

16. When Mr Gifford read an article or advertisement in the Daily Mail praising a revolutionary new laser surgery implant which improved the eyesight of those with AMD that was available from Dr Qureshi and the LEH, the claimant was keen to find out more. She understood from the article that the treatment was currently only available privately as it was fairly new, but it was hoped it would later be available on the NHS and they were looking for people to become guinea pigs at reduced cost – she anticipated that the surgery would be done for less of the proposed cost. They got in touch with LEH and Dr Qureshi and arranged an appointment. On 15 July 2013 they travelled from their home in Tydd St Giles, Wisbech Cambridge, approximately 100 miles to the second defendant's premises in Harley Street. London, W1 to attend an appointment with Dr Qureshi.

17. At that meeting, as recorded in the cursory notes made, the claimant was explicit that the purpose of her interest in the surgery was to improve her eyesight so that she could read magazines again and that she wanted the surgery on her worse left eye. Dr Qureshi assured her that he could help her see better and that she should have surgery on both eyes. However during the course of the appointment she was persuaded to

have both eyes done, because she was worried that her right eye would deteriorate and Dr Qureshi suggested it would be sensible to have both eyes treated. She was insistent and Dr Qureshi agreed, that the surgery should be performed on the left eye first with the operation on her right eye to follow a few weeks later. She was clear that she did not want to risk her much better eye, as if anything was to go wrong on her right eye, it would be devastating.

18. There was no mention of her being a guinea pig or that it was some sort of a trial. I conclude that if any impression had been given from the Daily Mail article that it was in some way experimental surgery, it was dispelled at the consultation. From what she was told by Dr Qureshi, she was confident enough to agree to proceed and paid the full cost of surgery to both eyes – £11,000 per eye together with £1,500 extra for use of a femtosecond laser which she was told would reduce the risk of infection totalling £25,000 – before setting off back home to Cambridgeshire with an appointment date. She was enthusiastic to proceed as evidenced by her willingness to part with a large sum of money for both eyes at the initial consultation.

19. I find that Mr Qureshi did not explain any risks of surgery beyond the possibility of infection which, he said, would be reduced by the use of the femtosecond laser that she had paid extra for. He did not effectively communicate that it might not work or that she could have any problems. He did not share with her any of what little research data that there was about the limited benefits and risks of the proposed surgery for someone with her level of AMD in both eyes. He told her that he was confident that he could make her sight better and she believed him. She does not appear to have been informed of the inherent risks of any intraocular surgery. She had severe lesions and it is common ground the limited case studies that had been considered in an optically similar lens showed that patients with severe lesions of the type the claimant had in her right eye experienced only a slight improvement in vision and there was no possible benefit that could be obtained from the surgery to her left eye. She was asked to sign various documents which she did not pay much attention to.

20. Although the claimant does not mention it in her statement, the second defendant's records show that on 15 July 2013 she undertook a simulator exercise to demonstrate to her the possible benefits of the surgery and the notes record that the achievable improvement on her right eye would be in the range of 6/24-2 to 6/15-2 and in her left eye she would be able to count fingers. The experts and the first defendant were of one mind that the proposed surgery would not enable her to read magazines again. The notes record that she was sight impaired (partially sighted) with large macular lesions bilaterally and central vision in the right eye but no central vision in the left eye. She relied entirely on the visual function of her right eye.

21. There is no evidence that the pro forma (P8.4 bundle 2/2 the red file) checklist of advice to patients at consultation document was discussed with the claimant in detail by Dr Qureshi and I do not accept at face value the cursory notes that merely record that there was a long discussion and the claimant was aware that AMD may progress and the medical risks of surgery. I find that the potential risks and benefits and the availability of any other measures was not properly discussed with her. If they had she would not have signed up for the surgery.

22. The notes made from that appointment did not record which eye was to be operated on and Dr Qureshi failed to record the claimant's clear and explicit instructions that her left eye be operated on first.

23. The second defendant was promoting what was referred to as a second-generation of lens implants. The first generation, IOL-VIP was approximately 10 years old by then and the name for the second-generation lens used by the second defendant was IOL-VIP Revolution. The modification from the first-generation lenses was that both discs were placed behind the iris, whereas first-generation lenses placed one of the two discs in front, and the other behind, the iris and is an "in the bag" IOL implant.

24. At the time there, there was little in the way of studies or academic literature of the first generation IOL-VIP and none in respect of the IOL-VIP Revolution lens. A 2007 paper (Orzalesi et al in 2007 and Colenbrander et al in 2007) suggested only a slight improvement could be achieved if combined with post-operation training for those with severe lesions. There is no evidence that the claimant was ever told that the operation would, at best, result in a slight improvement in vision. The Royal College of Ophthalmology Guidelines published on 5 January 2013 advised that:

> "We don't know how much improvement it [either the IOL-VIP and the new IOL-VIP Revolution telescopic implant lenses] can give, and we don't know if patients with dry macular degeneration and reduced vision could benefit. It is likely that only a proportion of those with severe macular degeneration in both eyes could benefit. At present it is difficult to advise patients properly or to recommend this type of surgery for them."

The paper went on to explain that it was too early to consider it for NHS use until there were published studies of the outcomes of surgery in a large group of patients.

25. As mentioned above, LEH is now in administration. Dr Qureshi, director of LEH, has had his name erased from the GMC and been struck off for putting his financial interests above those of his patients at LEH and is no longer able to practise as a doctor. His treatment of elderly and vulnerable patients was found to have been deliberately misleading following a Medical Practitioners Tribunal Service hearing which heard from 24 of his former patients at LEH (none of whom was the claimant) in September 2019.

26. The first defendant is an experienced NHS consultant doctor working in Reading. He was also keen to extend his private practice beyond Reading to the capital. To that end he approached a number of private surgeries and hospitals, but the second defendant was the only place with an opportunity for him. He commenced an arrangement with them in late July 2013 following a meeting and discussions in June of that year with the non-clinical manager, David Briggs, , who agreed he could conduct eye surgery through them.

27. He quickly observed that there was little of the support that had been promised to the clinicians, there was an ever-changing group of surgeons and the administration was chaotic with confusion over appointments and bookings. He stopped taking new patients in March 2014. He explained that he was not content with the premises, the

treatment of doctors, the treatment of nurses and the treatment of patients and he concluded it was not a safe environment in which to look after patients. However he received a number of new patients from August to November 2013 and operated on approximately 10 to 15 patients at LEH. His evidence was that he realised in a short space of time - September or October 2013 - that it was not a safe place in which to practise, but until he stopped the arrangement, he lived with his misgivings.

28. The claimant was his 4th or 5th patient at LEH. He reviewed the notes made at the 15th July appointment and decided that the right eye should be operated first and the lens was ordered for the right eye. He requested she attend for further tests on 5 August prior to the operation scheduled for 23 August. She was given no further information about the surgery, it's risks or possible benefits or the availability of any alternatives to IOL-VIP Revolution implants on 5 August 2013, but tests were conducted by the optometrist. After and during the tests the optometrist was adamant that her right eye was worse than her left eye. The claimant tried to correct her, but was contradicted by the optometrist who insisted that her right eye was worst. The claimant and Mr Gifford, who was with her, felt unable to argue. The optometrist was wrong – her left eye remained the one with very limited vision.

29. The claimant did not have any glaucoma in either eye as can be seen in the photographs taken that day, prior to the surgery. Nor was there any significant noticeable asymmetry in the optic nerves of both eyes.

Surgery on 23 August 2013

30. On 23 August 2013 the claimant and Mr Gifford returned to LEH for the operation to be conducted at their Wimpole Street hospital. Her daughter, Ms Ozturk remembers her mother's excitement in anticipation of the operation and how much she was really looking forward to being able to see better and being able to read again.

31. In the waiting room drops were applied to her eyes in preparation for the operation. She had been told on 15 July by Mr Qureshi that he would be performing the operation and was therefore surprised to be introduced to the first defendant who came into the waiting room, after the drops had been applied, and be told that he would be her surgeon. He told her he would be operating on her right eye. When she explained that it had been agreed that the operation should be performed on her left eye, he said the lens had only been ordered for the right eye.

32. She and Mr Gifford went into another room with the first defendant where it was discussed further with her. The first defendant told her that the right eye should be done first as it "would help to balance the vision". She did not understand what he meant by this. He told her that she had the option to cancel or postpone the surgery and put the operation back by 1 and ½ hours for her to consider. I find that he did not have a detailed discussion with her about the risks including the potential loss of vison due to infection, pressure and retinal detachment. Nor was she warned that there was a risk that she might need further surgery on the right eye. She was given the impression that since the surgery was to take place on both eyes, it was a minor detail as to which eye was operated on first. The first defendant did not tell her that there would be no potential benefit from surgery to her left eye. She had been told that the surgery would improve her eyesight and she had not been told that it might not work. She had trusted Dr Qureshi and the first defendant. She was not told that she may not

achieve reading vision nor was there any discussion of Low Visual Aids as an alternative to surgery. However she had not found the LVAs that she had tried at the Fakenham Medical Centre to be particularly helpful, hence her desire to explore other possibilities. She then signed the consent forms that were not explained to her and that she could not read because of the eye drops that had been administered.

33. I shall pause in the narrative to explain why I have rejected the first defendant's evidence that he went through the risks and possible outcomes of the surgery in meticulous detail before obtaining the claimant's consent for him to operate on her right eye. The statement of the claimant made just 2 years after the surgery and the statement of Mr Gifford had the ring of truth and were inherently plausible and were consistent with both her letter of complaint in March 2015 and her response to LEH's reply to her letter of complaint. She had been absolutely clear throughout both that she wanted to read again and did not want to risk jeopardising the sight in her right eye. So if the first defendant had given an accurate assessment of the likely benefit to be obtained from the surgery and warned her of the risks, it is implausible that she would have consented.

34. The first defendant did not suggest that he had informed the claimant before the operation on 23 August 2013 that surgery to her left eye was pointless. Yet that was an important and highly relevant piece of information to her decision to proceed with surgery to the right eye. As the first defendant had only just started working with the LEH, one can perhaps understand why he may not have wished to explain that no medical benefit could be obtained from the left eye surgery that Dr Qureshi had sold her. The date for the second surgery appears to have already been set up by then for 27 September 2013, although this did not in fact take place. I therefore preferred the evidence in chief of the claimant and Mr Gifford to that of the first defendant, even though it could not be tested in cross-examination, on the consenting process on 23 August 2013.

35. I infer from the claimant's very great and consistent caution from the beginning about surgery to her right eye, that if she had been aware of the risks and the very limited potential benefit, she would have decided not to have the operation on her right eye either on 23 August 2013 or on any later date.

36. The operation was performed reasonably competently by the first defendant as day surgery. She was then aged 79. It was neither necessary nor advisable to perform a peripheral iridectomy (PI) prior to the surgery and Mr Morris readily accepted that he was wrong in this regard in his initial report.

37. The first defendant accepted that as the surgeon in the case, he was responsible for ensuring that the claimant had given informed consent prior to any surgery conducted.

Post-operative care

38. The first defendant also accepted and agreed with the joint experts' opinion that a surgeon, such as himself is responsible for a patient's aftercare, even if it is shared with the LEH to administer some of the care. In a patient with raised eye pressure who has recently undergone intraocular surgery, the ultimate responsibility lies with the treating physician. The first defendant considered himself to be responsible for the

claimant and her post-operative care and made himself available to the LEH and was regularly in contact with them to perform his duty.

39. The factual issues narrowed during the course of the hearing so that whilst the claimant considered that the post-operative care from 23 August 2013 to 6 November 2013 was sub-optimal, it was not negligent. The facts for August and October can therefore be taken fairly briefly and concentrate on the intraocular pressure or IOP to her right eye and the first defendant's diagnosis and treatment.

40. It is common ground that the claimant developed glaucoma in her right eye as a result of the surgery from 25 September to 11 December 2013, which she would not have done if the surgery had not been performed. It damaged her optic nerve resulting in the total loss of vision: by end of January 2015 her optic nerve had died and she had lost all sight in her right eye. The diagnosis of the specific form of glaucoma – which is a generic term - is a material dispute of fact between the parties which is relevant to both liability and causation.

41. Although immediately after the operation the claimant was able to see some letters out of her right eye, the improvement was shortlived and by 18 September 2013 she could only count fingers at 1 metre. She also had problems with pain and inflammation as well as having worse eye sight than before the surgery. She returned to LEH on 27 August, 18 September and then 25 September 2013.

42. It is common ground that raised IOP is indicative of glaucoma – or more accurately the risk of damage to the optic nerve – and that glaucoma should be treated as soon as raised pressures are identified. It is also common ground that glaucoma is a common occurrence following lens surgery.

43. Eye pressure needs to be measured as a patient will be unaware of the pressure in his or her eyes. The claimant's eye pressure first caused serious concern when she returned to LEH on 23 September when it had increased to 45 in her right eye, but remained stable at 14 in her left. Her normal right eye pressure was 18 and it had been 20-22 the previous week. There is no criticism of the first defendant's treatment on that occasion when he stopped the claimant's steroid medication. Increased eye pressure is a known possible response to steroid eye drops, which can take 2-4 weeks to occur. By then she could no longer count fingers with her right eye, but could still identify hand movements.

44. On or shortly after that appointment the first defendant sought advice from specialists at Moorfields Eye Hospital and spoke to a glaucoma fellow, consultant ophthalmic surgeon, Mohammed Abu-Bakra in Professor Foster's team. He recommended treatment with eye drops and systemic medication such as Diamox as a temporising measure. If control was not achieved by this means, then YAG laser iridotomy/surgical iridectomy also referred to as peripheral iridotomy (PI) should be performed. If PI did not work to control the pressure then the advice was to remove the implants. Everyone agreed that this was correct advice. I accept the evidence of Dr Abu-Bakra that in order correctly to diagnose and treat high eye pressure it is crucial to have accurate current pressure readings, gonioscopy findings, optic nerve state and visual field results. No gonioscopy measurements of the claimant were taken at that time however.

45. The first defendant saw the claimant again the following week on 2 October when the right intraocular pressure remained at 40, but no reading was taken of her left eye, which would have been best practice. In accordance with Dr Abu-Bakra's advice he correctly prescribed Diamox to try and bring her eye pressure down as rapidly as possible. Her eye pressure was then checked at Boots in Grantham on 9 October when the pressure had reduced to 18, but there remained a disparity with her left eye with pressure recorded of 11 on that date.

46. Although Dr Abu-Bakra's statement is silent as to the timing of each stage of possible treatment and he does not say how long he recommended the first defendant should wait before moving to the next step, both experts agreed that time is critical and that the longer the optic nerve is exposed to raised eye pressure the more it is likely to be permanently damaged with significant effect on a patient's eye sight. Ideally PI will be performed within 48 hours. It was important for the first defendant to ensure that the claimant continue to be closely monitored and her eye pressure checked.

6th November 2013

47. The claimant returned to the LEH for an appointment on 6 November 2013. The first defendant said that he was not aware in advance of this appointment – one of his frustrations with LEH was their failure to advise him of his patient appointments – and his evidence in chief was that he did not see her on this date. In cross examination however he stated he could not remember whether he saw her on that occasion. He said however that the notes made by the optometrist at the appointment, Nicola Wood, would have represented a thorough account of what was discussed. The first defendant did not at any point in his evidence suggest that he would have done anything differently to the treatment recorded in the notes of 6 November.

48. An issue arose as to whether the first defendant had signed the prescription given to the claimant that day. He disputed that it was his signature. No handwriting expert evidence was before me and I am not a handwriting expert. Nor did the first defendant call Nicola Wood, the optometrist with whom he worked extremely closely and whom he trusted completely, who would have been able to give direct evidence as she had made the notes of the consultation on 6 November 2013. Nor did the first defendant disclose his own records and diaries from 2013 to the claimant which would have proved his whereabouts on that date[1] and if he had been at the LEH on 6 November 2013. Obviously if his diary had shown that he was not in the LEH on that date either it cannot have been his signature on the prescription, or it has been incorrectly dated. In support of his evidence that it was not his signature the first defendant stated that he never used biro, that he never underlined his signature and he always printed his name out and would not have written his name as a signature in both the name and signature section of the prescription form. However, as Ms Presland elicited in cross examination from other examples of his signature and prescriptions in the bundle, he did use biro on other occasions, there were examples of him underlining his signature and he had also written his signature in both the line for his name and for his signature on other prescriptions. To an untrained eye, however, I accept that the signature is not exactly the same as some of the other examples in the bundle, but his signature does

[1] We know he still has his personal records and diary for 2013 as he referred to them in cross-examination in relation to another date (no longer relevant) and explained that he had checked them to ascertain his whereabouts on that other occasion. He was asked to produce them for the next day's hearing but did not do so.

vary considerably from document to document. Ultimately all I had was the first defendant's say so.

49. Since both parties have required the court to make a finding on the point, on balance of probabilities, I find that it is the first defendant's signature. It is more inherently probable that he signed the prescription form than not and in the absence of handwriting expert evidence there is no corroborating evidence to support his assertion.

50. On balance of probabilities I also find that he saw the claimant on 6 November. The claimant's statement does not mention her ever seeing other doctors and describes the process of seeing the optometrist first, the implication being that that was before she saw the first defendant. It is also apparent that the first defendant did make the effort to be available for the claimant and did not walk away from his post-operative role. The notes made by Ms Wood are also consistent with the first defendant undertaking the consultation himself as a direction is made about how to contact him whilst away on study leave and that he wanted to be telephoned. I infer that these were instructions given by the first defendant during the consultation.

51. But whether he signed the prescription or not, and whether he saw her or not, he directed and approved the treatment and prescription given that day and he agreed that Nicola Wood would have consulted with him and obtained his instructions having relayed the test results that day. So if I am wrong about both his signature on the prescription and presence at the consultation, it is not such a central point as the parties sought to present.

52. The claimant's right eye pressure had spiked again in three readings of 39, 40 and 37 which was a very concerning reading on 6 November 2013. It could no longer be explained by the steroid eye drops which had been stopped 5 weeks prior.

53. He prescribed a continuation with medication and decided not to perform PI which was the next step recommended by Dr Abu-Bakra. Pilocarpine, a recognised treatment for pupil block glaucoma was prescribed together with Ganfort and Acetozolani. The claimant was asked to return in 2 weeks. No gonioscopy was conducted on 6 November. Both experts were agreed that it should have been, even though it is an unpleasant procedure for the patient. It was necessary to assist in diagnosis and treatment at that stage.

Compliance

54. The first defendant's expert, Professor Claoué, considered that although the normal course would be to perform PI within 48 hours of such a high eye pressure reading after the previous history of intermittent high IOP the previous 2 months, it was reasonable for the first defendant to wait for a further period of time after 6 November 2013 before performing PI because the claimant had been non-compliant with medical advice.

55. He based his argument on the record of 6 November 2013 that the claimant had stopped all drops 2 days previously and had had no drops that day. Professor Claoué therefore considered that the increased eye pressure recorded on 6 November 2013 could have been explained by the 2 previous days without eye drops and that in his

experience patients under report non-compliance. He considered a reasonably competent doctor could wait before performing PI to see if a period of compliance with the medication regime worked first. A doctor should impress on the patient most strongly the importance of taking the medication and the position reviewed within 2 weeks thereafter. Mr Morris considered that it was negligent not to perform the PI within 48 hours of 6 November.

56. I find that there is no evidence of the claimant not being compliant with the treatment prescribed to her. She has been meticulous and diligent in returning to appointments in London whenever requested to do so. It is to be remembered that it was a 200 mile round trip requiring her and Mr Gifford to drive into central London. A far more likely explanation for her not having taken the drops for the previous 2 days on 6 November 2013 was because her 28 day prescription, last given on 2 October, had run out. The first defendant has not suggested, and nor do the notes record, that she had been told that the eye drops were time critical. It would be reasonable for her to assume that if she had an appointment 2 days hence, that she could wait till then to get more, if the doctor were to repeat the prescription.

57. If there had been wilful non-compliance the notes taken by Ms Wood would have recorded the stern advice that any doctor would give to their patient. The notes however are silent. Nor did I accept that there were other hints in the evidence of non-compliance by the claimant. When she has raised concerns about, for example, one medication causing a tingling sensation, there was no suggestion that she had stopped taking it to avoid the unpleasant side effect. Nor was the first defendant's assertion that the claimant went on holiday to Australia and New Zealand in early 2014 against his advice borne out by the contemporaneous records. There are a number of references to her trip and none of them suggest it is against doctor's advice. They merely mention how she can keep in touch while she is away. Finally the assertion that the claimant failed to attend a scheduled appointment on 27 December requires closer scrutiny. The first defendant's statement exhibits an email exchange between Ms Wood and Mr Gifford in which he refers to the claimant "waiting to hear" from the first defendant on 27 December. It would seem that they were expecting a telephone call from the first defendant on that day, which would explain their not attending the surgery. The email is also revealing as it demonstrates an anxiety to ensure that the advice and medication is followed to the letter:

> "How many and how often to do I take the Ganfort. The Xavatan and the Cosopt do I take then as directed from today or wait to hear from Mr El-Amir on 27th. Sorry if I am interrupting your evening, Betty"

58. It is also worth remembering that the claimant worked for 10 years as a psychiatric nurse and would be well versed in the importance of following doctor's orders. I therefore do not find that there was non-compliance by the claimant of the treatment regime or that the first defendant could have reasonably concluded that she was non-compliant from the fact that eye drops ran out 2 days prior to her appointment with him on 6 November 2013.

Timing of PI surgery

59. The issue between the experts is whether PI should have been performed that day, or within 48 hours, in light of the continued high right eye pressure. I accept and prefer the evidence of Mr Morris in this regard, which was effectively conceded by Professor Claoué, subject only to his compliance point which I have rejected for the reasons set out above.

60. I find as a matter of fact, that it was negligent for the first defendant not to have urgently performed a PI on the right eye to attempt to relieve the right eye pressure within 48 hours of the appointment on 6 November 2013. That was the treatment recommended by Dr Abu-Bakra following the failure of the medication regime and both experts agreed that it was essential for it to be conducted quickly. Both experts agreed that permanent damage to the optic nerve was caused by the delay, although they disputed how significant that permanent damage would be.

61. If the cause of the claimant's glaucoma had been pupil block or angle closure a PI performed on 6th November or shortly thereafter would have relieved the pressure and prevented any further damage. If the cause of the raised pressure had been UGH syndrome, it would have made no difference.

Cause of the raised eye pressure

62. The experts disagreed as to the cause of the glaucoma. In order to resolve that important factual dispute between them, and the dispute as to the significance and scale of the permanent damage that was caused by the delay, it is first necessary to make a few general observations on their respective evidence.

63. Both experts were equally well qualified in the relevant field. The fact that Mr Morris had not personally performed IOL-VIP surgery was immaterial – first hand practical experience provided him with no additional insight to the disputed issues in this case when the standard of surgical performance was not in dispute. Both experts remain in clinical practice and it is not significant that Professor Claoué retired from the NHS a number of years ago.

64. But Mr Morris readily accepted that he had been mistaken in his initial report and he was open and frank in withdrawing his initial concern that PI should have been performed before the IOL-VIP Revolution implant. He accepted that he had not read the source material carefully enough to note that it applied only to first generation IOL-VIP implants in reaching his initial conclusion. He realised his error at the joint meeting with Professor Claoué as is recorded in their joint statement and he informed the solicitors instructing him. It was an isolated error that does not taint or impact on the rest of his report.

65. He was a clear and articulate witness able to explain his opinions and the reasons why he had reached them. He also demonstrated a willingness to listen and reconsider points in light of the evidence and questions from Mr Spaeight. For example, when the chronology of events from 25 September 2013 was explored in detail with him in the light of the first defendant's oral evidence, he agreed that the medical advice and treatment from 25th September to 6th November was good enough not to be considered negligent.

66. Professor Claoué however was somewhat evasive in his answers at points and slow to concede points that were contrary to the evidence with some doggedness. When directed to be more focussed in his answers and address the question asked, he became unhelpfully defensive and monosyllabic before finding a better balance. Even though his performance in the witness box was in part explained by his never previously having given evidence in the civil courts, and I am well aware of the limited value of a witness's demeanour in assessing their evidence, it combined with his inability to explain why he considered the very rare condition of UGH to be the cause of the claimant's glaucoma. Mr Morris also noted that at the joint meeting Professor Claoué had been unable to explain why he disagreed with his pupil block glaucoma diagnosis. Professor Claoué pointed to the claimant's reduced IOP on 20 November- 27, 27, 28 in her right eye - to suggest that the first defendant had been correct to adopt a wait and see approach, but the IOP was still far too high and both experts agreed on the importance of the need for speed in dealing with raised IOP and I attach little significance to the IOP reading on that date. It was not sufficient evidence, to support Professor Claoué's opinion.

67. I accept Mr Morris's opinion that, on balance of probabilities, the cause of the claimant's glaucoma was angle closure or pupil block, which is consistent with the prescription of Pilocarpine on 2 October 2013 and the more obvious and likely explanation. Pupil block glaucoma is very common after eye surgery although it is less common when a crystal lens is removed. UGH is however exceedingly rare.

68. The drawings of the claimant's eye conducted in her consultations in November and December are also consistent with angle closure glaucoma. But perhaps the most persuasive point of all is that UGH is a condition that occurs when the lens of the eye has been in contact with other tissue in the eye. In the surgery performed on the claimant, so-called "in the bag" surgery, the lens was in the capsular bag and cannot have been in contact with other eye tissue. Professor Claoué had no explanation for this.

69. I therefore reach the finding that it was more likely that the permanent damage to the claimant's optic nerve was caused by pupil block glaucoma which would not have occurred if there had been PI performed on or shortly after 6 November 2013.

70. PI was in fact performed on 13 December 2013 5 weeks later. The claimant's right IOP was measured again on 11 December 2013 and found to be at 31,30, 31, (after the reading 2 weeks earlier on 20 November at 27, 27 and 28) when the first defendant decided to operate. The notes from 6 November to the date of surgery show that the AC (anterior chamber) was open but narrow on 20 November and quiet, in contrast to the assessment prior to the surgery in July when it is recorded as deep and quiet.

71. I accepted Mr Morris's evidence that the 5 week delay to surgery at the raised right eye IOP would have made a material contribution to the ability of the claimant's optic nerve and her peripheral vision. Professor Claoué was unconvincing when he stated that the damage, albeit permanent, was not serious. His opinion involved a degree of speculation and it was not possible to conclude that there was enough surplus capacity or space in the optic nerve for the damage to have made no difference to her peripheral vision. As Mr Morris said, even one additional week of raised IOP at the levels experienced by the claimant was likely to make a material difference.

72. By 19 February 2014 the claimant had end stage angle closure. The combination of the AMD in her central vision with the end stage angle closure which affected her peripheral vision resulted in the claimant's total blindness in that eye by January 2015.

73. The intraocular pressure in the claimant's left eye has remained in the normal range consistently throughout the period both before and after the surgery to her right eye and she has no glaucoma in her left eye.

Discrepancies in records

74. Much time in court was spent examining the documents which appeared in different versions at pp 351, 352 and 353. The original documents were obtained from the administrators of LEH and it does appear that one set of photocopied documents was inaccurate. There is no suggestion that either the claimant or the first defendant's side are in any way involved in any inappropriate behaviour in relation to these documents. I entirely understand the first defendant's concern about the omissions and apparent alterations from the documents, but none of the issues in this case turn on it, the explanation (whatever it is) is more likely to be innocent, and all parties agree that the original documents are the accurate ones and the copies with missing parts can be simply ignored and no more be said about them in this case.

The law

75. The applicable law in this case is familiar and uncontroversial. The well-known *Bolam* test (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582) is that a doctor will only have been negligent if the claimant proves that he or she has not acted in accordance with a practice accepted as proper by a responsible body of medical practitioners skilled in that particular art. It is not a gold standard or best practice requirement but a reasonableness test. It is important to bear in mind (see *Bolitho v City and Hackney Health Authority* [1996] 4 All ER 771) that it is not for the judge to substitute her own assessment of what would have been an appropriate standard of care, the standard is that considered appropriate by a reasonable body of skilled medical opinion and the substitution trap is to be avoided.

76. Nor were the parties in dispute as to the scope of the duty of doctors to obtain informed consent before conducting a procedure and the leading case of *Montgomery v Lanarkshire Health Board* [2015] UK SC15 that

> "An adult person of sound mind is entitled to decide which, if any of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it" (paragraph 87)

and

> "An important consequence of this [the obligation to give protection to the patient's right of autonomy] is that it is not possible to consider a particular medical procedure in isolation from its alternatives. Most decisions about medical care are not simple yes/no answers. There are choices to be made, arguments for and against each of the options to be considered, and sufficient information must be given so that this can be done." (paragraph 109, per Lady Hale).

77. The parties agreed that since the claimant's case was that she would never have agreed to have had any eye surgery (either on 23 August 2013 or on any later date) if she had been made aware of both the risks and the very limited prospect of any improvement from the operation, the potential area of legal uncertainty deftly set out by Mr Speaight concerning the precise scope of the *Montgomery* modification of usual principles of causation (see *Duce v Worcestershire Acute Hospitals* [2018] EWCA Civ 1307) was not relevant in this case.

78. It was of course common ground that the claimant must still both plead and prove with evidence that if the correct information had been given (in the event of the claimant establishing liability), that she would not have had it (*Correa v University Hospital of North Staffordshire* [2017] EWCA Civ 356.

Discussion and conclusions

79. The first defendant considers he was something of a victim of LEH. He was duped by LEH and Dr Qureshi and has never been paid the promised £800 for undertaking the surgery and the aftercare that he undertook and oversaw. He was shocked to learn of the disparity between his fee and the amount paid by the claimant to LEH and to learn that she had paid extra for Femtosecond when it was part of the surgery itself. He would not have undertaken surgery on the left eye and considered it unethical for the claimant to have been sold it. He went out of his way to arrange for her to be reimbursed for the left eye surgery which did not take place.

80. In his evidence, the first defendant was at pains to stress the additional pressures that the chaotic organisation of the LEH placed on him alongside his busy NHS practice in Reading and that he had sought to behave responsibly towards his patient, to the extent of obtaining advice from the specialist team at Moorfields Eye Hospital and making sure that the claimant could contact Ms Wood at any time. I accept that he found himself in a difficult situation in his first experience of private practice in London and no doubt had been hoping to develop a lucrative practice in due course.

81. However the issues in this case are narrow and concern specifically the consenting process on 23 August 2013 and the failure to perform PI between 6th November and 13 December 2013. It will, I hope, be of some comfort to the first defendant to know that his treatment of this patient is not said to have been negligent in any other respects. It is the nature of clinical negligence cases such as this to examine the specific surgery in question to consider if it was performed to the requisite standard and I have worked from the presumption that in relation to other aspects of his treatment of this patient, and in respect of all his other patients he performs his work

to a competent standard. I have not drawn any inferences from the other claims that have been brought against him by other patients treated by him at LEH and only considered the evidence relating to this patient.

Liability and causation: informed consent

82. As will be apparent from the findings of fact, the informed consent of the claimant was not obtained from the claimant before she underwent surgery and the first defendant was negligent in the consenting process. The first defendant failed to take all reasonable steps to obtain her informed consent to ensure she was aware of the very limited potential benefits of the surgery which would not have enabled her to read again, which was the reason for her interest in the surgery. Nor did he inform her of the very considerable risks and dis-benefits of operating on her only good eye. I cannot conclude that pro forma documents produced by LEH were explained and gone through with her. Merely putting back the surgery on the day for 1 ½ hours for her to consider the change of plan to operate on her functioning eye was wholly inadequate in the circumstances. As eloquently put by Ms Presland, she arrived at the hospital for elective surgery for which there was no medical need to be told it would be performed on a different part of her body than she had anticipated. The preservation of the functioning of her right eye was, understandably, of great importance to her.

83. The first defendant failed to inform the claimant of the published data for the procedure, which did not support reasonable outcomes for patients with her level of AMD; failed to give her adequate information which would have allowed her to establish that there were significant risks to the procedure; failed to inform her of the risks of performing surgery in her better vision eye when she had such poor vision in her left eye; failed properly to consent the claimant by sufficiently explaining the risks of losing sight in her only good eye and performing the surgery without having provided her with the material information. He also failed in his duty towards her by omitting to tell her on 23 August 2013 that surgery could improve the sight in her left eye.

84. If she had been correctly informed that the surgery would not have enabled her to read magazines again and carried a risk of complications she would not have elected to have the operation on her right eye on that, or any other day.

85. Mr Speaight noted the claimant's enthusiasm for the operation and that for some patients, even the chance of a slight improvement would be worth the risk of surgery. Everything is, of course, relative and for the better sighted amongst us it may be easy to overlook the significance of a small improvement. But her clearly stated and specific aim was to be able to read again and that would not be achieved with this operation. Her instructions were clear and at no point did anyone tell her that she would not obtain her desired outcome. Her willingness to agree to the surgery on both eyes at her first meeting with Dr Qureshi is evidence of her vulnerability and susceptibility to exploitation, not her determination to proceed with surgery against medical advice.

86. But for the surgery, her right eye would not have developed glaucoma. The health of her left eye is good evidence as to what would have happened had she not had the IOL-VIP Revolution implant and her left eye remains glaucoma free. She lost all

peripheral vision because of the surgery. Her dry AMD would have continued and her central vision deteriorated to the level of her left eye over a 3 to 5 year period to the level of her left eye as at July 2013, with or without surgery.

87. Liability and causation are therefore established against the first defendant in relation to consent.

Liability and causation: failure to conduct PI between 6 November – 13 December 2013

88. In light of my conclusion on the negligent failure to obtain the claimant's consent for the operation and the acknowledgement by Mr Speaight that it logically follows that the first defendant is liable for all the consequences of her subsequent glaucoma, the second set of negligence allegations become somewhat academic. But they are live allegations before me and the parties are entitled to my conclusions.

89. The failure to proceed to a YAG PI within 48 hours of the consultation on 6th November 2013 also fell below the standard of care required of the first defendant towards the claimant. I have found, on balance that he saw her personally on 6th November 2013, but if I am wrong about that, Mr Speaight conceded in his closing submissions that he would have been consulted, was fully up to speed with what happened on 6 November and did nothing to alter the diagnosis and treatment given on that date. He was therefore aware of her dangerously raised right eye IOP for a woman of her age, whether he personally signed the prescription or not.

90. I have found the claimant to have been compliant with her treatment regime and accordingly do not find her to have been contributorily negligent.

91. As I have found that the glaucoma was likely to have been pupil block glaucoma, had the PI been performed in a timely manner, she would not have lost her peripheral vision.

92. In terms of causation, Mr Speaight skilfully wove an argument that the claimant had failed to prove that the 5 week delay in the PI had caused any damage to her optic nerve because it represented a 25%-33% period of raised eye pressure and the damage had either already been done, or, in the alternative, occurred later during the course of 2014. Even if the precise amount of damage caused by the 5 week delay may never be known, and even though we will never know for certain what form of glaucoma damaged the claimant's optic nerve, the 5 week delay was a material contribution to the damage caused and had the PI operation been performed on or shortly after 6 November 2013 it is likely that the damage would not have been as extensive as it was at 13 December 2013. It is likely that there was already some significant and permanent damage by 6 November, but she would have still retained some considerable peripheral vision. She had continued high IOP for the further 5 weeks before the PI was performed. The reduction to a pressure reading of 28 on 20 November was still far too high and I conclude that the further delay made a material contribution to the total loss of her vision in her right eye and the death of her optic nerve.

93. I therefore find that in relation to the second set of allegations the first defendant failed to provide the claimant with advice, care and surgical treatment to the reasonable standard expected which caused the glaucoma damage to her right eye

leaving her with no perception of light in that eye and that the first defendant is liable to her in damages.

94. Following receipt of the draft judgment pursuant to PD40E2.4 Mr Beaumont for the first defendant included in his list of typing corrections an application to remove mention in paragraph 81 of the other claims that had been brought against the first defendant on grounds that they were irrelevant. He submitted that they should not have been cited by the claimant and were very damaging and an unwarranted encouragement to others. I decline do so. It is important for the parties to know that I have not taken those matters into account because, as Mr Beaumont explains, they are irrelevant, but since the evidence was before me he needs to know that I paid it no regard. An unrelated amendment to the judgment sought by Mr Beaumont was a qualification of the conclusion at paragraph 90 to enable the first defendant to advance arguments of contributory negligence in the quantum hearing "in diminution of damages". I decline to place a gloss on paragraph 90.