Neutral Citation No. [2014] NIQB 117 | *Ref:* **STE9404**

Judgment: approved by the Court for handing down | *Delivered:* **23/10/2014**
*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

_____

QUEEN'S BENCH DIVISION

_____

JAMES McGOVERN

Plaintiff:

-and-

JAMES A SHARKEY
and
BELFAST HEALTH & SOCIAL CARE TRUST

Defendants:

_____

STEPHENS J

Introduction

[1] The plaintiff, James McGovern, 64, brings this action alleging medical negligence against Mr James A Sharkey, FRCS, FRCOphth, Consultant Ophthalmic Surgeon ("the first defendant") who was responsible for the private treatment of the plaintiff, particularly in respect of his right eye, at the Hillsborough Clinic and at the Ulster Independent Clinic between 23 November 2006 and 1 August 2007. The plaintiff also alleges negligence against the Belfast Health and Social Care Trust ("the second defendant") on the basis of their vicarious liability in that the plaintiff also received treatment at the Royal Victoria Hospital ("RVH") from the first defendant who is employed as a Consultant at that hospital by the second defendant and from other servants or agents of the second defendant.

[2] In essence the plaintiff alleges that at 1.30 a.m. on 26 December 2006 he in fact suffered a Rhegmatogemous Retinal Detachment ("RRD") in his right eye. That on 4 January 2007 when he was seen by the first defendant it was acceptable not to arrive at that diagnosis but rather it was appropriate to diagnose an Exudative Retinal Detachment ("ERD") and that it was then reasonable for the first defendant to treat with steroids. However it is the plaintiff's case that the differential diagnosis of RRD

should have been kept constantly under review and given that it was suggested that in a significant percentage of cases a retinal tear cannot be seen without performing an operation which enables the inside of the periphery of the retina to be visualised with the assistance of illumination and a much higher degree of magnification, and given what is suggested was a lack of response or adequate response to steroid treatment thus raising the index of suspicion that an RRD was present, that a vitrectomy ought to have been performed. That the only way to conclusively check whether a retinal tear was present would be by performing a vitrectomy and that 6 to 7 months later checking the diagnosis by a vitrectomy would mean that if a retinal tear was then found the visual outcome for the plaintiff would be appalling. That ultimately if one continues to wait before carrying out a vitrectomy then the eventual outcome is total loss of sight in the eye. That if a vitrectomy had been performed retinal tears would have been discovered and repaired as in fact this was an RRD rather than an ERD or alternatively was both an RRD and an ERD. That such an operation ought to have been carried out at the start of the February 2007 given the known risk of deterioration of the retina after a period of six weeks. In fact an operation was not carried out until 3 September 2007. The plaintiff asserts that the delay in performing the operation meant that the chance of a successful visual outcome both in terms of visual acuity and field of vision had been radically adversely affected.

[3] In essence both defendants state that, at all material times, the correct diagnosis was of an ERD secondary to an idiopathic inflammatory process (idiopathic panuveitis, which is uveitis, inflammation of the uvea, affecting the anterior chamber and the posterior uvea) and the correct treatment was given. That the diagnosis and the treatment, were in accordance with a recognised body of medical opinion and that the differential diagnosis of an RRD was kept in mind and steps were repetitively taken to determine whether the plaintiff had a retinal tear by inspecting the retina with, for instance a slit lamp with the eye dilated and by an indented examination under local anaesthetic. That there is no practice of performing a diagnostic vitrectomy for a retinal tear whenever the preferred diagnosis is ERD. That ordinarily the mean time to performing an operation in the context of an ERD is 6 months. Furthermore that the risks of performing such an operation on an eye with an inflammatory process were unwarranted until after a graduated response with steroids had proved to be unsuccessful.

[4] Mr Lockhart Q.C. and Mr Egan appeared on behalf of the plaintiff. Ms O'Rourke Q.C. and Mr Park appeared on behalf of both defendants.

The plaintiff's present circumstances and the assessment of potential damages

[5] The plaintiff's vision in his right eye is now 6/120. There is no chance of any recovery. This loss of vision is to be seen in the context that the vision in his left eye is significantly reduced being 6/36 on the Snellen chart. The reduction of vision in his left eye is due to amblyopia in his left eye (a lazy eye) and cystoid macula oedema which is a progressive condition. It is probable that over the next 10 years

there will be further visual field constriction towards central fixation with further reduction in left visual acuity. The prospects for the plaintiff are dreadful and his situation has been compounded by a recent diagnosis of multiple sclerosis. His method of coping includes a degree of avoidance in that he does not wish to contemplate what further deterioration and the progression of his conditions will have on the quality of his life. He lives on his own having separated from his wife some years ago. He cannot drive. He bumps into things. He can read by dint of the use of a magnifying glass but this requires considerable effort. To watch television he has to sit right beside it. His ability to exercise is restricted by his visual impairment. He presents as a frail individual though with remarkable courage and considerable determination.

[6] If there is a finding of a breach of duty in this case together with a finding that the breach caused deterioration in vision in the plaintiff's right eye then I would make a number of awards. I would award £25,497 being the medical cost of the treatment that the plaintiff received for both of his eyes in England as I find that but for the assumed negligence he would have received treatment for both of his eyes at the Royal Victoria Hospital on the NHS. I would have awarded £75,000 for loss of past and future earnings. There is no arithmetical way of calculating compensation in this case for loss of employment given the numerous uncertainties: see *Blamire v South Cumbria Health Authority* [1993] PIQR 1. The plaintiff impressed me with his level of determination and commitment which would have been far more evident but for the visual disability in his right eye. I have no doubt that given his experience and abilities he would have sought and obtained employment. As far as general damages are concerned if there was a retinal tear present in February 2007 and if there was negligence then I prefer the evidence of Mr McHugh as to the chances of a successful outcome. The plaintiff would not have regained his previous visual acuity but I consider that he would be able to drive and to work. The outcome in the context of the state of his left eye and given his personal circumstances would lead me to an award of general damages of £200,000. The total award would be one of £300,497.

Factual findings as to matters including terminology, procedures and treatment together with some conclusions in relation to the standard of care

[7] This case involves the difference between two forms of retinal detachment namely, an RRD and an ERD. I start with a description of the structure of the eye and then with a description of these two forms of retinal detachments. I will summarise in outline the treatment for each of them and also set out the method used in this case for testing visual acuity.

[8] The structure of an eye includes at the front the anterior chamber followed by the focussing mechanisms, which are principally the cornea and the crystalline lens. At the back of the eye is the retina that receives focused light and converts it into electrical impulses that are sent to the brain for processing via the optic nerve. The most sensitive portion of the retina is known as the macula. In the functioning of a

normal eye, light is typically focussed on the macula, within which is the sensitive area, known as the fovea. In the main cavity of the eye, between the lens and the retina, is a jelly-like substance known as the vitreous.

[9] The detachment of the retina in both an ERD and an RRD is caused by the presence of fluid behind the retina in the sub retinal space. There will always be a degree of fluid in the sub retinal space and there is a physiological mechanism, in layman's language a pump, to remove that fluid. However in both an ERD and an RRD the quantity of fluid behind the retina exceeds the body's capacity to remove it. The fluid accumulates and the retina floats off the structure to which it is attached. This detachment can be complete or in any part of the retina. In this case it was initially in the anterior half of the retina but became complete. Once the retina detaches, then visual function starts to deteriorate. If only a peripheral portion of the retina is detached then the visual deficit will be restricted to reduction in the field of vision relating to that area of retina. The patient may describe at this juncture symptoms of a 'grey curtain', or blurring in their peripheral field, or distortion. However if the retinal detachment spreads to involve the most sensitive portion of the retina known as the macula, then more pronounced visual deterioration will occur. If fluid from an extending retinal detachment tracks under the fovea and lifts it away from the underlying structure, central vision will be lost. The terms "macula on" and "macula off" retinal detachment refer to whether the retinal detachment is peripheral to the macula or involves that area. If the macula is attached, the patient's visual acuity may be normal (or at least remain at the premorbid level). Therefore, if the retina is successfully reattached before macula involvement occurs, the patient may continue to enjoy normal or stable vision despite the occurrence of the detachment. However, once the macula is detached, even if the retina is successfully subsequently reattached or becomes reattached, it will take considerably longer for the vision to recover and indeed may never be restored to the level that existed prior to the occurrence of the detachment. Accordingly macula status is of vital clinical relevance in relation to the visual outcome.

[10] The difference between an ERD and an RRD is the cause of the presence of fluid in the sub retinal space.

[11] In an ERD the cause is, for instance, inflammation which generates fluid behind the retina. There can be other causes for fluid accumulating behind the retina in an ERD such as:

a) excessive permeability of the blood vessels of the choroid deep to the retina;
b) a defective pumping action of the retinal pigment epithelial cells between the neuro-retina and the choroid
c) an infection,
d) a neoplastic cause
e) systemically associated cause (for example hypertension or Chrone's disease).

[12] In an RRD the cause of the fluid accumulating behind the retina is a tear in the retina which permits fluid to pass from the vitreous through the hole caused by the tear to the area behind the retina.

[13] The standard treatment for an ERD is to treat with steroids which can be administered in a number of ways. The simplest is by drops into the eye but other methods are orally, or by injection in the area of the eye or by injection into the eye. The aim of the treatment in this case is to reduce or eliminate the inflammation and therefore to eliminate the production of fluid so that the retina can then reattach by naturally settling back onto its supporting structure. If a graduated response, with different types of steroids applied in different ways and at different strengths, fails then surgery can be performed. The aim of the surgery is to drain the area behind the retina which will involve creating a hole in the retina, then sealing the hole and re-attaching the retina to its supporting structure.

[14] The treatment for an RRD is to perform an intra-ocular operation either within 24 hours in a "macula on" RRD so as to avoid the risk of the macula detaching or within one week in a "macula off" RRD. The aim of retinal detachment surgery is to remove fluid from under the retina and close the retinal tear, this being the cause of the detachment. In a vitrectomy this is achieved by removing the vitreous, performing laser treatment, or cryotherapy to the tear in order to seal the tears and also in order to attach the retina to its supporting structure. Thereafter injecting a bubble of gas, or silicone oil into the vitreous cavity to support the retina until the break is securely healed. After the operation and for a period of time the patient has to adopt a specified posture in order to keep the bubble of gas in the correct position in order for it to perform the function of holding the retina in place. An alternative technique to a vitrectomy is to apply a "buckle" to the outside of the eye with the aim of closing the break by creating an internal ridge.

[15] In an RRD draining the area behind the retina, closing the hole or holes in the retina and fixing the retina to its supporting structure resolves the problem in that fluid can no longer enter through a hole and cause the retina to re-detach. The position is more complicated in an ERD. The cause of the fluid is, for instance, inflammation. An operation does not resolve and can exacerbate the inflammation and accordingly even if the fluid is drained and the retina is re-attached the continuing or increased inflammation will cause further fluid and the retina will simply detach again. Accordingly the primary treatment for an ERD is with steroids but it is recognised that if the fluid does not resolve over a period of say 6 months that this may be due to it having accumulated too much protein or other bioactive chemicals and the presence of these is preventing the fluid from being re absorbed naturally. So at that stage there is justification for operating to drain the fluid in an ERD with the prospect of it not recurring despite the fact that the operation does not address the underlying cause which is the inflammatory process. The median time between the onset of symptoms in an ERD and such an operation being performed was stated to be 6 months in a paper published in 2008 by *Galor and others* with the range being 3 – 15 months.

[16] In all retinal detachments, whether an ERD or a RRD, the longer the period that elapses between the retina detaching and subsequently re-attaching then the worse the outcome. In an *acute* retinal detachment, the retina tends to be "mobile" and it is easier for it to re-attach with the resolution of fluid in an ERD and it is technically easier to reattach the retina during surgery in an RRD. A *chronic* retinal detachment (of typically more than a month), will develop membrane formation on the surface of the retina, a feature that is known as proliferative vitreoretinopathy ("PVR"). This causes "stiffening" of the retina, rendering reattachment more difficult. Apart from the technical challenge during the course of an operation of reattaching a retinal detachment with PVR, the visual prognosis for a chronic retinal detachment is worse: the longer the retina has been detached, the poorer the visual outcome due to the development of irreversible microscopic retinal damage.

[17] The cause of retinal tears in an RRD may vary. Typically the vitreous jelly may undergo a process of shrinkage and collapse within the eye and in so doing strip away from the retina to which it is normally loosely attached causing what is termed a posterior vitreous detachment ("PVD"). A PVD may develop spontaneously (typically in older individuals), or may occur as a result of ocular trauma. This traction (or pulling) on the retina may in turn induce the formation of a tear in the retina. Another cause may be iatrogenic, that is medically induced. The vitrectomy operation may itself cause a tear either by the instrument piercing the retina or the insertion of the instruments causing traction on the vitreous which in turn causes the tear. Furthermore an intra-ocular injection may also cause a retinal tear. The two peripheral superior retinal tears found in this case at operation on 3 September 2007 were U shaped and this shape is consistent with a tear caused by either a process of shrinkage or by traction on the vitreous during the vitrectomy on 3 September 2007 or during the intra ocular injection performed at the RVH on 17 May 2007.

[18] Both an ERD and a RRD can cause the symptom of floaters. In an RRD the floaters are due to condensations forming in the vitreous, bleeding from damaged retinal blood vessels, or the release of pigment cells from beneath the retina. On examination these are seen as having an appearance in the vitreous similar to "tobacco dust." In an ERD floaters are due to inflammatory cells in the vitreous. On examination these are seen as clumps of white cells.

[19] Both an ERD and a RRD can cause symptoms of flashing lights either at the time of the detachment or subsequently. The brain may interpret the signal from the retina via the optic nerve as it is detaching or when it moves after it is detached as flashes of light.

[20] Accordingly the symptoms of floaters and flashing lights can be present in both an ERD and an RRD.

[21] In an RRD the location of the retinal tear or hole is relevant to the length of time it takes for retinal detachment to occur. It is also relevant as to whether a track or gutter forms from the location of the tear to the position in which the fluid accumulates. In relation to speed if the retinal hole or tear is *superiorly* positioned, then due to the effect of gravity sub-retinal fluid will tend to accumulate more rapidly, resulting in a macula-off detachment forming possibly within 24-48 hours of the tear formation. If the retinal hole or tear is inferiorly located then this may still engender a retinal detachment but generally it will progress more slowly. In relation to a track or gutter if the retinal fluid accumulates *inferiorly*, as it did in this case and if the retinal tear or hole is positioned *superiorly*, as the holes found at operation on 3 September 2007 were, then the fluid has to pass behind the retina from the superior position of the hole to the inferior part of the retina where the fluid accumulates. This transfer of fluid forms a track or gutter and whilst the hole may not be visible there must be and will be a track or gutter which should be very visible on slit lamp examination or on an indented examination under local anaesthetic.

[22] The purpose of an indented examination is to push the peripheral areas of the retina into view enabling a search for a hole or tear in the peripheral parts of the retina which are difficult to visualise. The best results are achieved under local anaesthetic as an indented examination involves pushing the eye with in effect a stick and if the patient is anesthetised he is less likely to pull away which would have the effect of reducing the amount of indentation. If the patient has low ocular pressure, as the plaintiff did in this case, it is easier to push the eye and accordingly easier to visualise the peripheries of the retina. An indented examination of this type was performed by the first defendant on the plaintiff. A hole or tear can be hard to see in that the torn part of the retina may not be protruding so in addition the first defendant used the application of pressure together with a twisting movement in an attempt to make any hole or tear stand out. The aim of the twisting movement is to lift the flap of any retinal tissue which hangs down and to enable it to acquire a three dimensional and therefore more visible aspect.

[23] An ERD can be associated with a number of systemic conditions such as Chrones disease. Accordingly when an ERD is diagnosed it is appropriate medical practice to carryout tests for those conditions. If the tests are positive then a referral would be made to a medical specialist for the other condition but the treatment of eye remains exactly the same, namely the application of steroids. Ordinarily the patient will present with some symptoms of the systemic condition but this is not always so and accordingly it is appropriate practice to test for those conditions even in the absence of symptoms so that if the condition is present *it* can be treated appropriately. In this case no such investigations were carried out by the first defendant. It is accepted that if they had been they would all have been negative. I find that this failure to carry out those tests in this case fell below an acceptable standard in the *Bolam* sense in that there is either no responsible body of medical opinion that would not have carried out those tests or alternatively there would be no logical basis for a body of medical opinion that would not do so. The plaintiff did

not allege or seek to establish that this failure to take care had any causal significance. There was no evidence to that effect.

[24] The way in which sub-retinal fluid responds after a change in the patient's posture is an indicator as to whether the retinal detachment is an ERD or an RRD. The method of testing is to examine the sub-retinal fluids after the patient has been lying on his back or on one side and then to change the posture of the patient so that for a period he is lying on his other side. Thereafter there is a further examination of the sub-retinal fluid. After a change in posture the configuration of the detached retina, when observed with indirect ophthalmoscopy, alters immediately owing to the movement of sub-retinal fluid in the sub-retinal space to the most dependent part of the globe. Thus, with inferior shifting sub-retinal fluid, rotation of the plaintiff's head from side to side results in the transfer of sub-retinal fluid from one inferior quadrant to the other. Most RRDs do not show shifting sub-retinal fluid but an ERD cannot be diagnosed without shifting sub-retinal fluid. However shifting sub-retinal fluid can be observed in an RRD particularly when the RRD is relatively longstanding and the retinal holes are small. Ordinarily when the tear or hole in an RRD is large there is a rapid movement of fluid out of the sub-retinal space rather than shifting in that space. In a paper published in the British Journal of Ophthalmology in 1985 by *Kirkby and Chignell* there were 25 RRDs with shifting fluid out of a total of 470 cases. However, only one of those 25 cases had shifting fluid within one week of the retinal detachment with none in the period 1-2 weeks. Accordingly the presence of shifting fluids within 2 weeks of an RRD was one out of 470 cases. Mr Aylward FRCS FRCOphth, MD, Consultant Vitreoretinal Surgeon at Moorfields Eye Hospital, gave evidence, which I accept, that to have shifting fluids within 9-10 days of an RRD is extremely rare and if it was present on 4 January 2007 in the plaintiff's case, which is within that time frame, then it was a significant and very powerful clinical indicator of an ERD.

[25] The location of inflammation is of importance in that inflammation in the front of the eye would not be expected to cause an ERD but inflammation in the posterior chamber would be consistent with an ERD. So inflammation in the uvea would result in white cells in the vitreous which cells tend to clump together (vitritis) together with thickening of the sclera.

[26] A reduction in sub retinal fluids is a diagnostic criteria for ERD not RRD. The reason for the presence of fluids in an RRD is the hole or tears in the retina and unless and until that is resolved there will not be a reduction in fluid. The reason for the presence of fluids in an ERD is for instance an inflammatory process and accordingly if there is an improvement or reduction in the level of inflammation this can result in a reduction in the amount of fluid.

[27] In association with both an ERD and an RRD it is expected that the intra ocular pressure will be affected. 18 is considered to be a normal pressure and in an RRD the reduction in pressure is expected to be in the region of 12, 13 or 14. A pressure of 4 would be extremely unusual in an RRD but very common in an ERD.

The reason for this in an ERD is that the uvea is connected to the organ of the eye that produces the fluid and maintains pressure so when the patient has inflammation of the uvea, particularly when the patient, as in this case has separation of the pars plana, that separation leads to reduction of output of the organ of the eye that produces fluid and accordingly very low intra ocular pressure.

[28] The presence of scleral thickening is associated with ERD and it is not a feature of an RRD which does not cause any scleral thickening.

[29] ERDs can be resistant to steroids.

[30] The vast majority of retinal detachments are RRDs. ERDs are rare and those ERDs which require surgery are exceptionally rare.

[31] Diagnostic vitrectomy is a recognised procedure to exclude lymphoma and to investigate possible infective aetiologies. I accept the evidence of Mr Aylward that there is a respected body of medical opinion that would not perform them in a situation where the clinical signs are of an ERD to exclude the possibility of an undetected retinal tear or hole. I am not persuaded that there is any opposing body of medical opinion that would perform a diagnostic vitrectomy in such circumstances.

[32] It is a feature of retinal tears and holes that they can be hard to detect even with diligent pre-operative examinations. Mr McHugh's evidence was that in 8% of cases of retinal detachment no breaks are identified pre-operatively and are only seen at surgery. In giving that evidence he relied on a paper published in October 2009 by *Vincent Martinez-Castillo and others*. That paper post-dates the events in 2007 in this case but I accept that it has been well known for years that a break or tear might not be seen even with diligent pre-operative examinations. However, I do not consider the figure of 8% applies in this case. The *Martinez-Castillo* paper is a study of patients with primary RRD which can be diagnosed despite the lack of a detectable break. For instance a diagnosis of an RRD might be based on the appearance of "tobacco dust" as a finding on examination despite there being no visible tear or hole. Further instances of the diagnosis of an RRD despite being able to see a visible tear or hole would be a finding on examination of a gutter or track or the lack of shifting fluids or the lack of any inflammation or the lack of any other cause of a detachment. I accept the evidence of Mr Aylward that there is no report anywhere in the literature of an eye with all the clinical features of an ERD subsequently being re-diagnosed as an RRD. I also accept his evidence that there is no report anywhere in the literature of patients having a diagnostic vitrectomy with the outcome being a diagnosis of an RRD when it was not suspected on clinical examination. I reject the suggestion that the *Martinez-Castillo* paper supports the proposition that in 8% of cases with clinical symptoms of ERD there could be a tear or hole not capable of being identified pre-operatively. I also accept the evidence of the first defendant that at all times he kept in mind the risk that there was a tear or hole and checked diligently for such a feature.

[33] Operating on an ERD carries risks. Not only does the operation not address the inflammation and accordingly there is a risk of failure but also there is a risk of exacerbating the situation in a number of ways including increasing the level of inflammation. In the *Galor* paper published in 2008 it was emphasized that a complete medical evaluation and prolonged anti-inflammatory treatment is necessary before considering an operation because the risk of surgery is high and includes proliferative vitreoretinaopthy induced by the purposeful conversion of an exudative detachment into a combined detachment. Also in a paper published by *William H Jarrett* it is stated that ill-timed surgery may precipitate phthisis bulbi (very low pressure) in severely inflamed eyes and that the postoperative course was often stormy.

[34] Posterior scleritis is one form of ocular inflammation and it may be treated with systemic steroids, and orbital or intraocular steroid injections, together with non-steroidal anti-inflammatory agents. If the diagnosis is posterior scleritis then ordinarily a marked improvement in the inflammation may be observed over the course of 6 weeks after starting therapy. In this case the first defendant has used the term posterior scleritis but in his evidence asserts that this was used to indicate a finding rather than a diagnosis. That the thickening of the sclera was as a result of inflammation rather than being the cause of the inflammation. I accept that evidence.

[35] Visual acuity is defined as the ability to read a standard test pattern at a certain distance, usually measured in terms of a ratio to "normal" vision. The Snellen Chart provides such a standardized test of visual acuity. A version of the Snellen Chart was used in this case both by the first defendant at the Ulster Independent Clinic and by the triage nurse at the RVH. The chart is placed 6 metres from the subject. The charts may vary. They all consist of different lines of block letters, beginning with a large single letter on the top row. The number of letters on each row progressively increases moving from top to bottom. The size of the letters on each row progressively decreases, allowing for more letters on each subsequent line. The chart used by both defendants in this case consisted of 8 lines of block letters. Some charts have 11 lines. Visual acuity is stated as the ratio of distance compared to "normal" vision: the distance from the chart - 6 metres - is the numerator; the distance at which a 'normal eye' would be able to read the last line that the patient is able to read is the denominator. So the ratio is a ratio between a patient's performance and a standard or "a normal" performance. "Normal" vision or "normal performance" on the Snellen chart is 6/6 being the ability to read at 6 metres the seventh line on the chart used in this case. 6/6 is not perfect human vision. Good vision is generally much better than 6/6. A person with better than "normal" vision will have a denominator that is less than 6 e.g. 6/5 i.e. a person with this grading of visual acuity can read at six metres what a person with "normal" visual acuity can only read at 5 metres.

[36] Each eye is tested separately starting with the worse eye so that the patient has less chance of remembering the letters.

[37] The number of letters and the ratios for each line of the Snellen Chart used in this case starting with the first line are as follows:

a) First line, one letter, 6/60. The patient is able to read the one letter on the top line of the chart at 6 metres. A person with "normal" vision or "normal" performance would be able to do so at 60 metres.
b) Second line, two letters, 6/36
c) Third line, three letters, 6/24
d) Fourth line, four letters, 6/18
e) Fifth line, five letters, 6/12
f) Sixth line, seven letters, 6/9
g) Seventh line, 6/6
h) Eighth line, 6/5

[38] The last line that the patient is able to read is the denominator but on some occasions the patient is unable to read one or two letters in that line. In that case the denominator is qualified with minus one or minus two depending on the number of letters that he is unable to read. That signifies that he is able to read that line but not one letter or not two letters on that line. The denominator may also be qualified with a plus one or plus two which signifies that the patient can read one or two letters on the next line.

[39] If a patient is not able to read the top line of the chart at 6 metres then he will be placed closer to the chart. If he is able to read the top line at 3 metres then this visual acuity is expressed as either 3/60 or 6/120. 3/60 is an ability to read the top line of the chart at 3 metres in comparison to a person with normal vision who would be able to do so at 60 metres. Another way of expressing the same visual acuity is by the ratio 6/120 that is that the plaintiff is able read at 6 metres what a person with normal visual acuity could read at 120 metres.

[40] The margin of error in assessing visual acuity by reference to the Snellen Chart is accepted to be plus or minus one line on the chart. Accordingly for instance 6/60 and 6/36 are within the margin of error. The first defendant's evidence was that this margin allowed for variations as between one test and another in that the person performing the test can vary, the equipment can vary, the test methods can vary, the patient can be tested at different times of the day and the patient's responses or degree of application can vary. It was the first defendant's evidence, supported by Mr Aylward, that a large number of the variables were not present in this case in that the first defendant performed all the tests of visual acuity at the Ulster Independent Clinic using the same equipment and that all the tests were performed on the plaintiff at the same time of the day. Accordingly the first defendant contended, and Mr Aylward agreed, that a difference in visual acuity of one line on the Snellen Chart in this case, albeit within the ordinary margin of error,

justifiably acquired somewhat greater clinical significance so that a conclusion could be reached in their medical opinion, that there was some increase in visual acuity as a result of the treatment which the first defendant had instituted. I accept that evidence both factually and also as being consistent with an accepted body of medical opinion with a logical basis.

[41] Visual acuity for driving requires the patient to be able to read a standard size number plate (with glasses or corrective lenses if necessary) from 20.5 metres (67 feet) or 20 metres (65 feet) where narrower characters 50mm wide are displayed. This is a legal requirement and any person driving on a public highway who is unable to do this is guilty of an offence. There are also requirements as to an adequate field of vision. In rough terms visual acuity of 6/12 on the Snellen scale is sufficient to pass the number plate test.

Legal principles

[42] Disputes about questions of fact depend on the usual burden and standard of proof. However in relation to clinical or professional judgment the position is different. *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 established that, in determining whether a defendant has fallen below the required standard of care, regard must be shown to responsible medical opinion, and to the fact that reasonable doctors may differ. A practitioner who acts in conformity with an accepted current practice is not negligent "merely because there is a body of opinion which would take a contrary view." In *Hunter v Hanley* 1955 SLT 231 at 217 it was stated that

> "In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men … The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care … "

That test in *Hunter v Hanley,* was approved in *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635 and Lord Scarman also stated

> "It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. …

> Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other, but that is no basis for a conclusion of negligence.
>
> … I have to say that a judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. *For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another*. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary" (emphasis added).

[43] In *Bolitho (Administratrix of the Estate of Patrick Nigel Bolitho (deceased)) v City and Hackney Health Authority* [1997] 4 All ER 771 it was established that a doctor could be liable for negligence in respect of diagnosis and treatment despite a body of professional opinion sanctioning his conduct where it had not been demonstrated to the judge's satisfaction that the body of opinion relied on was reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field were of a particular opinion would demonstrate the reasonableness of that opinion. However, in a rare case, *if it could be demonstrated that the professional opinion was not capable of withstanding logical analysis*, the judge would be entitled to hold that the body of opinion was not reasonable or responsible. Accordingly the final arbiter as to whether there has been professional negligence is the court and not the medical profession. It is for the court to decide whether the requisite logical basis for a defendant's expert medical opinion is absent. The legal question is as to what features particularly characterise an expert medical opinion as one that is "illogical", "irresponsible", and "indefensible". It is clear that merely being a minority view of accepted medical practice does not, of itself, render that view "illogical" or "irrational" in the *Bolitho* sense. However it is suggested that a court would be more ready to find that the body of opinion was not capable of withstanding logical analysis if there was a dubious expert whose professional views existed at the fringe of medical consciousness, see *Khoo v. Gunapathy d/o Muniandy* [2002] 2 S.L.R. 414, at [63]. Another example would be "a residual adherence to out-of-date ideas" which "on examination do not really stand up to analysis" see *Hucks v. Cole* [1993] 4 Med. L.R. 393.

[44] It is however important to consider some limitations to the *Bolitho* test. A practice is illogical if there was a "clear precaution" which ought to have been, but was not taken. In this case the precaution that is suggested is that there ought to have been a diagnostic vitrectomy after one month given the risks of an unidentified tear of the retina and what is suggested was the lack of response to steroid treatment. However if there are risks attached to the precaution, in this case the risks associated with operating on an inflamed eye and the risk that the operation will not resolve the underlying problem, and one body of medical opinion considers that the risks ought to have been taken and the other does not then there is no "clear precaution" but rather a balancing of risks. In such circumstances both sets of expert opinion withstand logical analysis. For the plaintiff the expert opinion being that the risk of an adverse outcome, in that a tear was present in the retina, should have been prevented by taking the precaution of performing the vitrectomy. For the other body of expert opinion on behalf of the defendant, the precaution of performing a vitrectomy would have posed an unacceptable risk of operating upon an inflamed eye where given the diagnosis of ERD the operation would not have achieved a satisfactory outcome. This is merely a different weighing of risk rather than a determination that the defendant's expert opinion is illogical. The precaution that is being suggested is not a "clear precaution" but rather a precaution which involves a balancing of risks and that is a matter of clinical judgment with a logical basis.

[45] Another feature of applying the *Bolitho* test is that it introduces a lack of symmetry as between the plaintiff and the defendant's expert evidence. The defendant's expert has only to persuade the court that his views are capable of withstanding logical analysis, but he does not have to satisfy the court that the views of the plaintiff's expert are not capable of withstanding logical analysis. However, the plaintiff's expert has to do both.

[46] If the case is one that involves clinical judgment to which the *Bolam* test applies, and if the medical practitioner does produce evidence that his practice was supported by a responsible body of medical opinion, then, in the words of Sedley L.J. in *Adams v. Rhymney Valley DC* [2000] Lloyd's Rep. P.N. 777, at [41],

> "the judge or jury *have* to accept the opinion of a body of responsible practitioners, unless it is unreasonable [in the *Bolitho* sense]" (emphasis added).

Accordingly in an action involving clinical judgment there is a two-step procedure to determine the question of alleged medical negligence:

> (a) whether the medical practitioner acted in accordance with a practice accepted as proper for an ordinarily competent medical practitioner by a responsible body of medical opinion; and

(b) if "yes", whether the practice survives *Bolitho* judicial scrutiny as being "responsible" or "logical".

[47] Questions of fact and the question as to whether there was negligence are not to be conflated. Questions such as whether in the event there was a right retinal tear or hole in December 2006 or whether there was inflammation in the right eye in 2007 or whether there was scleral thickening in the right eye are questions of fact to be determined on the balance of probabilities with the onus of proof being on the plaintiff. The question of clinical and professional judgment as to whether a responsible body of medical opinion would form the view, in say January 2007, that there was a right retinal tear or hole or that there was inflammation in the right eye or that there was scleral thickening in the right eye are all subject to the *Bolam* test as qualified in *Bolitho*. In some cases the determination of a question of fact may lead inexorably to a finding that the medical practitioner did not act in conformity with an accepted current practice. In others it may have no such impact. So for instance in this case if there was a factual finding, on the balance of probabilities, that on 26 December 2006 the first defendant was informed that the plaintiff had suffered a sudden and profound loss of vision in his right eye and that the plaintiff's right eye was not assessed or if the plaintiff was not advised to have his right eye assessed that day then inexorably that would lead to a finding that the first defendant had not acted in conformity with an accepted practice. Inexorably because no logical accepted current practice would do or advise anything other than immediate action. However if the factual finding was that the first defendant was informed that the plaintiff had some extremely modest effect on his vision in conjunction with a history that drops had not been taken then (though there was a dispute about this) it *might* be that to delay an examination until 4 January 2007 and to recommend that the plaintiff use his drops was in conformity with a logical accepted current practice.

Credibility of the plaintiff and the first defendant and consideration of the expert and other evidence

[48] In assessing credibility I seek to apply the principles set out by Gillen J in *Thornton v NIHE* [2010] NIQB 4 where he stated

> "[12] Credibility of a witness embraces not only the concept of his truthfulness i.e. whether the evidence of the witness is to be believed but also the objective reliability of the witness i.e. his ability to observe or remember facts and events about which the witness is giving evidence.
>
> [13] In assessing credibility the court must pay attention to a number of factors which, inter alia, include the following;

- The inherent probability or improbability of representations of fact,
- The presence of independent evidence tending to corroborate or undermine any given statement of fact,
- The presence of contemporaneous records,
- The demeanour of witnesses e.g. does he equivocate in cross examination,
- The frailty of the population at large in accurately recollecting and describing events in the distant past,
- Does the witness take refuge in wild speculation or uncorroborated allegations of fabrication,
- Does the witness have a motive for misleading the court,
- Weigh up one witness against another."

[49] I have arrived at a number of factual conclusions adverse to the plaintiff based on my assessment of his presentation, on the fact that he deliberately failed to disclose his eye condition to his road traffic insurers and to the licensing authorities choosing instead to continue to drive when he knew that he represented a significant danger to other road users. I also consider that his recollection of events which occurred some 7 years ago was faulty.

[50] In relation to the plaintiff driving at a time when he knew that he ought not to be the evidence was that on 14 July 2008, that is after a series of operations involving both of his eyes, he purchased a two year old Volkswagen Passat four door salon motor vehicle. At that time the visual acuity in his right eye was totally inadequate to drive but the visual acuity in his left eye had improved to 6/12 by February 2008 and remained at that level throughout 2008. By February 2009 his left visual acuity had deteriorated to such an extent that he fell below the standard for driving and on 9 June 2009 Mr Ezra told the plaintiff that he should not be driving. The plaintiff agreed with Mr Ezra to adhere to that prohibition. In addition Mr Ezra wrote to the plaintiff's general practitioner and to the plaintiff's optometrist to inform them that the plaintiff should not be driving. Accordingly 11 months after the plaintiff purchased his motor vehicle he knew that he should not be driving. However he did not sell his motor vehicle until May 2014 some five years later. Also he did not cancel his motor vehicle insurance policy until 27 June 2014. At the date that he disposed of his motor vehicle its recorded mileage was 52,000. In his evidence the plaintiff stated, without producing any corroborative evidence, that when he purchased it that it had a very high mileage, which he estimated at 50,000.

[51] During that period he completed proposal forms for insurance declaring use of the motor vehicle for both business and social purposes with an estimated annual mileage of 14,000. He positively denied on one insurance proposal form that he had

defective vision not corrected by glasses despite a reminder of his legal obligation to inform the driver's medical branch of the DVLA if he had any disability that affects or may become likely to affect his fitness as a driver. On 19 May 2012 whilst driving his car he hit the entrance gate to his sister's house in the Balmoral area of Belfast causing damage costing £1,500 to repair. He mislaid his driving licence on two occasions and as a consequence he applied for a replacement licence. The first was on 24 October 2007 and the second in 2010. He lied to the licensing authorities on both of those forms in response to questions as to disability.

[52] On 2 December 2012 the plaintiff was seen by Mr McHugh MD, FRCS, FRCOphth DO, Consultant Ophthalmic Surgeon, who took a history from the plaintiff that "he can drive but has to exercise great care because of his reduced vision. He never drives at night."

[53] In an amended statement of claim stated to be served on an unspecified date in December 2013 but in fact served on 11 April 2014 the plaintiff alleged in the particulars of personal injury that "he does not drive at night". In his further amended statement of claim served 1 July 2014 the particulars of personal injury include an allegation that he "no longer drives". The plaintiff stated in evidence that as from November 2013 he stopped driving and that he kept his car so that his wife from whom he is separated and who has a car of her own could drive his car.

[54] In his evidence the plaintiff acknowledged that he lied to his insurance company and to the licensing authorities about his disability. He acknowledged that he had been in breach of the agreement with Mr Ezra that he should not drive. He stated that he only drove a short distance to church early on a Sunday morning and to a local shop again at a time of the day when there was little traffic. In relation to other journeys he asserted that he used taxis. I consider that quite irrespective of what he had been told by Mr Ezra it was quite obvious to him that he should not drive. He was prioritising his own needs. He lied consistently. He chose to imperil the lives of others. I consider that his evidence in court that he kept his car for the convenience of his wife from whom he was separated and who had her own car was also inaccurate to his knowledge. I consider that he drove to a greater extent than he was prepared to admit in his evidence and that he was not being candid.

[55] In broad terms I accept the evidence of Mr Sharkey. He presented in court as a dedicated, concerned, highly qualified and extremely experienced professional. Once he saw the plaintiff on 4 January 2007 he responded by seeing the plaintiff on a frequent and repetitive basis at the Ulster Independent Clinic without any fee being charged. This was in ease of the plaintiff who would otherwise have had to travel to the RVH and also to ensure that there was continuity of care. As is apparent I consider that in relation to some aspects of the first defendant's care of the plaintiff it fell below an acceptable standard in the *Bolam* and *Bolitho* sense. Accordingly there is the potential for an inference that if the first defendant reacted inappropriately on those occasions, that he did so on other occasions. I reject any such inference having seen and heard the first defendant. Also I consider that his recollection of events

was far more likely to be correct than that of the plaintiff. I come to that conclusion not only on the basis of the manner in which he gave his evidence but also on the basis that he had the advantage of being able to rely on the notes and records and also on his usual practice. There were numerous conflicts of evidence between the plaintiff and the first defendant and I do not intend to rehearse all of them but in general in order to resolve such conflicts in favour of the plaintiff I have looked for some degree of inherent probability or some degree of support in the medical notes and records. I give as an example one instance of a conflict of evidence between the plaintiff and the first defendant which relates to the plaintiff's assertion that on 29 March 2007 he requested the first defendant to arrange for a second opinion. The first defendant denied that any such request was made and also stated that if a second opinion had been requested he would have agreed. Having seen both the plaintiff and the first defendant give evidence and accepting as I do that there was no reason why the first defendant would not obtain a second opinion and also finding no support for such a contention outside of the plaintiff's evidence, I reject the plaintiff's evidence in relation to that allegation and prefer the evidence of the first defendant.

[56] Mr Aylward FRCS FRCOphth, MD, Consultant Vitreoretinal Surgeon at Moorfields Eye Hospital, was called on behalf of the first defendant to give expert evidence as to a responsible body of medical opinion. I accept that he represented a responsible body of medical opinion and that his opinions were both "truthfully expressed" and "honestly held." It is not necessary for the determination of this action to decide whether I preferred his evidence to the evidence of Mr McHugh, as in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of a professional opinion to another. However if the question of preference had arisen then I would have preferred the evidence of Mr Aylward for all of the reasons set out by Ms O'Rourke in her closing submissions including the external support for Mr Aylward's opinions in the literature, his personal experience of cases of ERD and the detail of his evidence, for instance, in relation to the measurement of scleral thickening with calipers, which evidence was subsequently and independently supported by the world expert in that field, Marie Restori.

[57] Mr McHugh, MD, FRCS, FRCOphth DO, Consultant Ophthalmic Surgeon, was called on behalf of the plaintiff to give expert evidence as to a responsible body of medical opinion. I consider that there was little, if any, support for his views in the medical literature. It was not put to him in cross examination that he did not represent a responsible body of medical opinion and in that circumstance I will proceed without deciding on the basis that his views represent a responsible body of medical opinion albeit a minority view.

[58] Marie Restori, Consultant Physicist at Moorefields Eye Hospital, gave evidence in relation to the ultrasound scans. She is an international and internationally recognised expert in the use of ultrasound in ophthalmic diagnosis

and measurement with over 30 years' experience in this field. In short she is a pre-eminent world class expert. I accept her evidence.

[59] Mr Ezra FRCOphth, FRCS (Glasgow), BEVRS, RSM, AAO Consultant Vitreoretinal Surgeon, Moorfields Eye Hospital and St George's Hospital, London, Honorary Consultant Vitreoretinal Surgeon Great Ormond Street Hospital gave evidence including his opinion as to whether the tears seen at operation on 3 September 2007 were long standing or caused in the operation. His evidence was arranged at short notice and understandably he had not considered the medical notes and records in detail. Despite being the operating surgeon and given that he had not considered the medical notes and records in detail I do not consider that he was in any better position than Mr Aylward to give evidence on the issue as to when the tears or holes occurred. Rather I prefer the evidence of Mr Aylward who had exhaustively analysed all the medical notes and records.

Factual background

[60] The plaintiff was seen at the Royal Victoria Hospital on 31 July 2006 complaining of visual deterioration in his left eye. Vision in his right eye was 6/6 -2 and in his left eye was 6/24 +1. Cataract formation was found in both eyes, being more pronounced in the left eye. On 23 November 2006 the plaintiff saw the first defendant at the Ulster Independent Clinic as a private patient. The vision in his right eye had deteriorated to 6/12 -2 and there was also a marginal difference in his left eye which was now 6/24 -2. Bilateral cataracts were noted and it was agreed that right cataract extraction and lens implantation surgery would be performed. The first defendant performed that operation at the Hillsborough Clinic on 11 December 2006. The operation was uneventful and the plaintiff was discharged having been instructed to apply a Maxidex drop 4 times a day to his right eye. Any eye operation carries with it the risk of inflammation and Maxidex is a steroid preparation which when applied to the surface of the eye penetrates to the anterior chamber. The purpose is to control any inflammation that might arise as a result of the operation.

[61] On the day after the operation the plaintiff was seen by the first defendant. The plaintiff gave a history that he was "well". His right vision unaided was 6/9 and on examination his eye was quiet with an occasional cell only in the anterior chamber which might have been some inflammatory activity. The pressure in his right eye was 16 which was within the normal range. The plaintiff appeared to be making an uneventful recovery from the cataract surgery. He was to continue to apply a Maxidex drop 4 times a day for 3 weeks and a review appointment was arranged at the Ulster Independent Clinic in 3 weeks times on 4 January 2007.

[62] The condition of the plaintiff's right eye deteriorated at 1.30 a.m. on 26 December 2006. The plaintiff had not been applying the Maxidex drops for the second half of Christmas Eve and on Christmas day. Accordingly, he had not applied 6 drops over that period. There is a debate as to the exact symptoms from

which the plaintiff was suffering when the condition of his eye deteriorated. In the original statement of claim the plaintiff alleged that he sustained "almost total loss of vision in the right eye". However the amended Statement of Claim deletes the words "almost total loss of vision in the right eye" substituting an allegation that in relation to his right eye he "developed symptoms of flashing lights and persistent floaters in his field of vision." The evidence is that the plaintiff's vision some 9 to 10 days later on 4 January 2007 was 6/60 unaided and that the plaintiff gave a history that he felt there was some improvement since starting drops but not as good as before. The measurement of visual acuity on 4 January 2007 establishes that there had been a substantial deterioration since the operation and indeed since the day after the operation. If there was some improvement of vision since the plaintiff started his drops then this would be consistent with an even more profound loss of vision on 26 December 2006 than was present on 4 January 2007. The fact that the plaintiff was aware of a profound loss of vision is also supported by the medical evidence that the date upon which he suffered a macula off retinal detachment was in the early hours of 26 December 2006. Furthermore the first defendant's letter dated 1 August 2007 states that

> "he (the plaintiff) rang me immediately after Christmas saying his vision had dropped fairly suddenly and profoundly on Christmas Eve. I saw him a few days later … ."

That is again entirely supportive of the proposition that on the balance of probabilities the plaintiff suffered a fairly sudden and profound loss of vision. The letter of 1 August 2007 was dictated by the first defendant to his secretary in the RVH without access to his private notes which he had left at home and without access to the RVH medical notes and records. It was dictated from memory and there are some inaccuracies in the letter in that the event occurred in the early hours of Boxing Day rather than on Christmas Eve and the plaintiff did not ring the first defendant but rather asked a nurse or liaison officer at the Ulster Independent Clinic to contact the first defendant. However despite those inaccuracies, I consider that the first defendant's memory of events at that time was far more likely to be accurate and accords with the sort of symptoms in any event from which it was likely that the plaintiff was suffering. Accordingly I find that in the early hours of 26 December 2006 the plaintiff suffered a fairly sudden and profound loss of vision in his right eye.

[63] A question arises as to the nature of any other symptoms from which the plaintiff was then suffering. The plaintiff asserts, but I am not prepared to accept, that he suffered from or encountered symptoms of flashing and floaters in his right eye. There is no record of any of those symptoms until he was seen by Mr McHugh, his independent expert, on 2 October 2012, some 5 years later. The symptoms of flashing lights and persistent floaters were not recorded on 4 January 2007 when the plaintiff was seen by the first defendant. It was not recorded at any subsequent

stage when the plaintiff was examined by Mr Hykin or when he was examined by Mr Ezra. I reject that part of the plaintiff's evidence.

[64] After the plaintiff suffered a fairly sudden and profound loss of vision in the early hours of 26 December 2006 he went to bed and then the next day he went with his sister to the Ulster Independent Clinic which is situated close to his home. The reception desk at the outpatients department was closed, it being the holiday period, and accordingly he went to the main reception desk. He gave an account of the condition of his right eye to the nurse or liaison officer on duty and she in turn contacted the first defendant. He gave an instruction to the nurse or liaison officer that the plaintiff was to use his drops and to attend for review as planned on 4 January 2007. That information was passed on to the plaintiff. The nurse or liaison officer cannot be identified. No note or record of those conversations was kept by the first defendant or by the staff at the Ulster Independent Clinic. I consider it inherently improbable that the plaintiff would not have given a fairly accurate summary of his symptoms when he attended at the Ulster Independent Clinic. It would also initially appear to be improbable that the first defendant would not have referred the plaintiff immediately to the Ophthalmic A & E department at the RVH if he had been told that the plaintiff had suffered a fairly sudden and profound loss of vision in his right eye but that is precisely what is recorded in the first defendant's letter dated 1 August 2007. Histories given by patients particularly when they are repeated second hand by an unknown nurse or liaison officer can be inaccurate. I am satisfied that at the very least the first defendant was not informed one way or the other as to the degree of the plaintiff's visual impairment and that he gave directions without any consideration of the degree of visual loss. I consider that was negligent in that at the very least there was equivocation or uncertainty as to the degree of visual loss from which the plaintiff was suffering and he should have been told that he required to be seen and assessed that day. I consider that the account that the first defendant received should have led to an immediate investigation and that there is either no responsible body of medical opinion that would not have investigated immediately or alternatively there would be no logical basis for a body of medical opinion that would not do so. The plaintiff did not allege or seek to establish that this failure to take care had any causal significance. There was no evidence to that effect.

[65] On 4 January 2007 the plaintiff was seen by the first defendant at the Ulster Independent Clinic. He gave a history:

> "Was going well until just after Christmas. Didn't use drops second half Christmas Eve and Christmas Day restarted after. Feels some improvement since starting drops but not as good as before. Better in mornings worse as day goes on."

The vision in his right eye was now 6/60 unaided improving to 6/36 with a lens. This was a substantial deterioration from, in effect, normal vision on 31 July 2006

and from the excellent level of visual acuity the day after his cataract operation. The first defendant examined the plaintiff and diagnosed an ERD involving the macula which also was "off" secondary to an inflammatory process. The treatment was to reduce the inflammation, therefore to reduce the fluid and to allow the retina to re-attach. In addition to Maxidex, which was to be continued, the oral steroid prescribed was Prednisolone starting at 60 mg and then reducing to 40 mg and then to 30 mg. Steroids are the appropriate treatment for inflammation. The aim of the treatment was to reduce the inflammation and therefore to reduce the fluid and to allow the retina to reattach.

[66] The plaintiff was then seen at frequent and appropriate intervals by the first defendant at the Ulster Independent Clinic and at the Royal Victoria Hospital. He examined the plaintiff's eye with instruments such as the slit lamp and also carried out ultrasound scans and examinations under local anaesthetic. The diagnosis remained ERD and there was a graduated response during the period January-June 2007 to treat the inflammation. This involved eye drops, oral steroids, oral non-steroidal anti-inflammatory tablets, 5 injections of steroids in the area of the right eye and when these had not succeeded an injection of steroids into the right eye followed by another injection in the area of the right eye.

[67] Ultrasound examinations of the plaintiff's right eye were performed at the Royal Victoria Hospital by the first defendant on four or five occasions. The ultrasound machine allows the image to be frozen and then printed off. At least one image was frozen and printed off on three of those occasions and those prints were kept with the medical notes and records. It may be that an image was printed off on the fourth or fifth occasions but if it was, it was not kept with the medical records and is no longer available. The dates upon which an ultrasound scan was, or in some cases may have been, performed, and the number of frames printed off and which are available are as follows:

a) 17 January 2007, one frame.

b) 26 January 2007, three frames.

c) 16 February 2007, no frames.

d) 20 April 2014, no frames. This ultra sound examination was planned on 19 April 2014 but there is no evidence that it was carried out

e) 27 June 2007, four frames available.

[68] The available freeze-frame images have been examined for the purposes of these proceedings by Marie Restori. Her evidence was that she examined the freeze-frame images and found subtle slight thickening of the coats of the eye that is both the choroid and the sclera, which would be consistent with mild posterior scleritis. She arrived at that conclusion by contrasting the different areas of the coats of the

eye finding that there was subtle slight thickening posteriorly. She found the same subtle slight thickening on all the images though it appeared to be slightly thicker on 27 June 2007. The assessment that I formed and I find that the impact of her evidence was that the subtle slight thickening had not altered over the period 17 January 2007 to 27 June 2007.

[69] It was also the evidence of the first defendant that the difference in thickening of the posterior sclera between the scans was not significant. He agreed that the degree of thickening on each scan was subtle and slight. There was said to be some improvement in the degree of scleritis on 16 February 2007 and on 27 June 2007 the note was "still significant posterior scleritis." However the first defendant explained and I accept that the word significant refers to the presence of thickening not the degree of thickening. It was the evidence of the first defendant that one could not carry out an accurate comparative measurement between all the ultra sounds by the use of calipers because one would have to carry out the measurements in the same plane and location on each occasion. I accept that explanation which was supported by Marie Restori. The first defendant accepted and I find that it was not possible as between the ultra sound scans to say anything else other than there was subtle slight thickening.

[70] The ultrasound scans showing mild posterior scleritis are compatible with an ERD. The first defendant's evidence is that he did not diagnose a primary posterior scleritis. The ultrasound scan is only a part of the picture and the clinical picture does not support such a diagnosis. Symptoms of posterior scleritis are severe and persistent ocular pain, restricted eye movements and proptosis (bulging of the eye). Pain is mentioned on one occasion but is not a feature thereafter. There was no restriction of eye movements and no bulging of the eye. Posterior scleritis responds well to steroid therapy and the plaintiff received significant doses of steroids over a protracted period but the ultra sound evidence of subtle slight thickening remained unaltered. In short there was no restoration of normal scleral thickness despite treatment. Furthermore there was an absence of any identifiable predisposing factors. The plaintiff did not have primary posterior scleritis despite the ultrasound findings. I accept the first defendant's evidence that he did not make that diagnosis but rather found that the scleral thickening was a consequence of the inflammatory process rather than a cause of it.

[71] As I have indicated during the period January-June 2007 the first defendant maintained the diagnosis of an ERD. The first defendant based that diagnosis on:

(a) The presence of shifting fluids on 4 January 2007 which was within 9-10 days of the retinal detachment on 26 December 2006. This was also noted on 11 January 2007 and 16 February 2007.

(b) Low intra ocular pressure of 3 on 4 January 2007, 4 on 11 January 2007 and 5 on 25 January 2007.

(c) The presence of inflammation in the posterior chamber as demonstrated by marked vitritis noted as vitritis +++ on 4 January 2007 with the degree of vitritis responding to steroid treatment so that for instance on 1 February 2007 it was noted as "much less" and on 15 February 2007 as "less".

(d) Inferior fluids with an inferior retinal detachment but with no track or gutter to any superior position.

(e) The lack of any visible holes or tears on examination including indented examinations under local anaesthetic.

(f) A reduction in the level of fluids in response to steroid treatment.

(g) The presence of scleral thickening on ultra sound examination.

(h) Some degree of improvement in visual acuity in response to steroids. The visual acuity on 4 January 2007 was 6/60 unaided and this improved for a period to 6/36 unaided.

[72] None of treatments applied by the first defendant were ultimately successful. Accordingly, on 14 June 2007 the first defendant advised intraocular surgery. This surgery would have involved the removal of vitreous, draining the fluid from behind the retina, re-attaching the retina and using silicone oil to maintain the position of the retina. The plaintiff was last seen by the first defendant on 29 June 2007.

[73] The plaintiff sought a second opinion from Mr Hykin at Moorfields Hospital in London. In order to facilitate the second opinion the first defendant wrote a letter of referral to Mr Hykin dated 1 August 2007. This also set out in summary form the diagnosis and treatment. There were a number of substantial errors in that letter which was dictated by, but not signed by, the first defendant. None of those errors impacted adversely on the plaintiff but they were not within a proper professional margin and I consider that the letter was inadequate.

[74] The plaintiff was seen by Mr Hykin on 3 August 2007 who examined both eyes and found a tear to the retina in the plaintiff's left eye which it is agreed developed at some stage between July and August 2007. He also considered that there was a distinct possibility that there was a tear in his right retina. Mr Hykin referred the plaintiff to his colleague, Mr Ezra, who first operated on the plaintiff's left eye and then performed a vitrectomy on his right eye on 3 September 2007. At operation Mr Ezra found two small tears in the upper periphery of the plaintiff's right retina. His right retina was reattached but on 10 December 2007 the plaintiff underwent a further operation to his right eye.

Conclusion

[75] I have found as a fact that the first defendant was not specifically asked by the plaintiff in March 2007 to arrange a second opinion. It is alleged that the first defendant fell below an acceptable standard of care in that of his own volition he did not request a second opinion and specifically an opinion from an expert in inflammatory conditions of the eye. The first defendant did not consider it necessary to seek a second opinion given the clear clinical signs of an ERD, his own level of expertise in that he had been trained in inflammatory eye conditions and that there was no dedicated inflammatory eye specialist in Northern Ireland. Mr Aylward's evidence is that this was in accordance with a practice accepted as proper for an ordinarily competent medical practitioner by a responsible body of medical opinion. I accept that evidence. I consider that this practice survives the *Bolitho* judicial scrutiny as being "responsible" or "logical" in that the diagnosis was of an ERD there being clear clinical signs and the standard treatment was being followed. If I am incorrect in that finding I consider that the plaintiff has not established that any different treatment would have been commenced if an inflammatory eye specialist had been consulted.

[76] Mr Aylward represents a respectable body of medical opinion. His evidence was that at the time and even with the benefit of hindsight the correct diagnosis in the period January-June 2007 was of an ERD and that the correct treatment was that used by the first defendant. Mr Aylward was of the opinion that the combination of symptoms makes the diagnosis of ERD not only reasonable but overwhelmingly likely. Indeed, he goes further and states that he would not have advised an operation for a further month. In essence he arrives at the diagnosis of an ERD on the same basis as the first defendant. Accordingly I hold that the first defendant acted in accordance with a practice accepted as proper for an ordinarily competent medical practitioner by a responsible body of medical opinion.

[77] I also consider that the practice survives *Bolitho* scrutiny as being "responsible" or "logical". To operate on an ERD does not address the cause of the generation of fluid and carries substantial risks.

[78] Those findings are sufficient to determine this case in favour of the defendants. However, I also find that the plaintiff has not established that the retinal holes found at operation on 3 September 2007 were in fact present any earlier than 17 May 2007 when the intra ocular injection was performed. I consider that the most likely cause of the retinal holes was pulling of the vitreous on the retina prompted by the intra ocular procedure and indeed potentially also by the operation which was performed on 3 September 2007. This is consistent with the symptoms of an ERD at an earlier stage and supported by the evidence as to the mechanics by which an iatrogenic tear or hole can be formed.

[79] The factual conclusion that no hole or tear was present until at the earliest May 2007 means that if an operation had been performed, as suggested by Mr McHugh in February 2007, then no hole or tear would have been found at that

operation. Accordingly, if there was any failure to operate in February 2007 it did not cause any adverse impact on the plaintiff's condition. Indeed, I accept that operating in February 2007 may well have led to a worse outcome for the plaintiff.

[80] I find for both defendants in relation to the issue of liability and dismiss the plaintiff's claim.