

**SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee
(the Committee)**

Information about the complaints process and the Committee is available at:
<https://www.cpsso.on.ca/Public/Services/Complaints>

**Dr. Brian Michael Curran (CPSO #63327)
(the Respondent)**

INTRODUCTION

The Complainant had cataracts. The Respondent performed intra-ocular lens (IOL) replacement surgery on the Complainant's left eye.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent failed to:

- **disclose, discuss or document details of the posterior capsule (PC) tear that occurred during left IOL replacement surgery;**
- **inform the Complainant that the wrong lens was inserted into his left eye during surgery; and**
- **to initiate discussion on management and options for future care as surgery for left IOL exchange is no longer possible, and every day the Complainant has ongoing symptoms of pain and blurred vision.**

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of January 23, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to disclosure of harm.

COMMITTEE'S ANALYSIS

Failed to disclose, discuss or document details of the PC tear that occurred during left IOL replacement surgery

PC rupture is a known complication of cataract surgery and complications do occur even with the best care. The Committee was therefore not concerned about the fact that there was a complication; rather, its concern was with how the Respondent disclosed it to the Complainant. Given that the Respondent's letter to the College minimizes the complication and seems to suggest it was somehow beneficial, the Committee wonders whether the Respondent clearly

explained to the Complainant that this was an adverse event. It is not accurate to describe PC rupture as an insignificant complication or somehow beneficial, as there is a long list of potential complications associated with PC rupture (though fortunately there is no evidence that the Complainant developed any of these complications).

Also, the Committee questions the Respondent's decision to disclose the PC rupture on the day of surgery while the Complainant was on the operating table recovering from the procedure. This was an inappropriate time to disclose the harm, or if he was to disclose the adverse event at that time, the Respondent should have discussed it in detail at a follow-up visit and documented this discussion.

For these reasons, the Committee determined it was appropriate to require the Respondent to attend at the College to be cautioned, as set out above.

Failed to inform the Complainant that the wrong lens was inserted into his left eye during surgery

The record demonstrates the Respondent inserted the correct lens in the Complainant's eye. The Committee took no further action on this concern.

Failed to initiate discussion on management and options for future care as surgery for left IOL exchange is no longer possible, and every day the Complainant has ongoing symptoms of pain and blurred vision

It is evident from the record that when the Complainant was unhappy with his vision after the surgery, the Respondent discussed the treatment options available. The Committee took no further action on this concern.