SUMMARY

DR. SHELDON DANIEL LEWIS (CPSO# 59558)

1. Disposition

On June 12, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") required cardiologist/internal medicine specialist Dr. Lewis to appear before a panel of the Committee to be cautioned with respect to failing to act in a timely manner regarding a patient with severe symptomatic aortic stenosis.

2. Introduction

A family member of the late patient complained to the College that Dr. Lewis failed to:

- keep a booked office appointment with the patient in May 2016
- have his office staff attend to the full voicemail mailbox for two weeks, making it impossible for the patient to re-book an appointment
- book an angiogram appointment for the patient in a timely fashion, even though he told the patient July 2016 that "if she didn't act on her problem, she might be dead within two years"
- respond in a timely fashion to the patient's family physician, when she attempted to follow up with him.

In his response to the complaint, Dr. Lewis explained why the May 2016 appointment was cancelled, set out improvements he has made in his office practice, and acknowledged telling the patient that she needed cardiac catheterization in anticipation of the need for aortic valve replacement, and that he had failed to book the angiogram in a timely fashion. Dr. Lewis acknowledged that his actions in this case fell below the standard of care expected of a cardiologist.

3. Committee Process

An Internal Medicine Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee concluded that the patient needed fairly urgent angiogram and valve replacement. The Committee was of the view that Dr. Lewis should have acted much more promptly in response to the patient's symptoms.

In spite of Dr. Lewis' apologies, remorse and the actions that he has taken to prevent this from happening again, the Committee was of the view that the appropriate disposition in the present case is to require Dr. Lewis to attend the College to be cautioned in person about his failure to act in a timely manner regarding a patient with severe symptomatic aortic stenosis.