Dr. Mozwa Bin TARATIBU

Council Decision

Date Charge(s) Laid:	March 19, 2016
Outcome Date:	November 18, 2016
Hearing:	September 26, 2016
Penalty Hearing:	November 18, 2016
Disposition:	Reprimand, Fine, Costs, Ethics Course

The Council of the College of Physicians and Surgeons imposes the following penalty on Dr. Mozwa Taratibu pursuant to The Medical Profession Act, 1981:

1. *Pursuant to section 54(1)(e) of The Medical Profession Act, 1981, Council imposes a reprimand upon Dr. Taratibu.*
2. *With respect to the finding of guilt on charge #1 and pursuant to Section 54(1)(f) of The Medical Profession Act, 1981, Council imposes a fine of $15,000 on Dr. Taratibu, payable forthwith.*
3. *With respect to the finding of guilt on charge #2 and pursuant to Section 54(1)(f) of The Medical Profession Act, 1981, Council imposes a fine of $2,500 on Dr. Taratibu, payable forthwith.*
4. *Pursuant to section 54(1)(g) of The Medical Profession Act, 1981, Council imposes that Dr. Taratibu successfully complete an ethics course on professionalism to the satisfaction of the Registrar. Such course shall be completed not later than May 15th, 2017. The programs "Medical Ethics, Boundaries and Professionalism" by Case Western Reserve University, "Probe Program" by CPEP and "Medical Ethics and Professionalism" by Professional Boundaries Inc., are ethics programs acceptable to the Registrar.*
5. *Pursuant to section 54(1)(i) of The Medical Profession Act, 1981, the Council directs Dr. Taratibu to pay the costs of and incidental to the investigation and hearing in the amount of $ 20,043.08. Such payment shall be made in full by December 31, 2016.*
6. *Pursuant to section 54(1)(g) of The Medical Profession Act, 1981, the Council directs that Dr. Taratibu will be suspended from the privileges of a duly qualified medical practitioner if he fails to complete the ethics course on professionalism as required and will remain suspended until he successfully completes that course.*
7. *Pursuant to section 54(2) if Dr. Taratibu should fail to pay the costs as required by paragraph 6, Dr. Taratibu's licence shall be suspended until the costs are paid in full.*
8. *Council reserves the right to amend the terms of this order by extending the time for payment of the costs, by arranging for the payment of costs over time or by installments,*

or by reducing or forgiving the payment of the costs and, in the event of such an amendment, the Council may impose such additional conditions pertaining to payment and suspension of Dr. Taratibu's license for the non-payment as may be permitted by The Medical Profession Act, 1981.

IN THE MATTER OF *THE MEDICAL PROFESSION ACT, 1981*, SS 1980-81, c M-10.1,
AND IN THE MATTER OF COMPLAINT AGAINST
DR. MOZWA TARATIBU, OF SASKATOON, SASKATCHEWAN

Decision of the Disciplinary Hearing Committee of the
College of Physicians and Surgeons of Saskatchewan

Hearing: September 26, 2016
Saskatoon, Saskatchewan

Panel:
Alma Wiebe, Q.C., Chair
Dr. Louis Coertze
Dr. Chris Ekong

No one appearing for Dr. Mozwa Taratibu

Mr. Christopher Mason and Mr. Bryan Salte, Q.C.,
for the College of Physicians and Surgeons of Saskatchewan

I. INTRODUCTION

The following charges were brought by the College of Physicians and Surgeons of Saskatchewan (CPSS) against Dr. Mozwa Taratibu who, prior to October 19, 2015, was a medical practitioner in Saskatoon, Saskatoon:

> The Council of the College of Physicians and Surgeons directs that, pursuant to section 47.6 of **The Medical Profession Act, 1981**, the Discipline Committee hear the following charge against Dr. Mozwa Taratibu, namely:
>
> You Dr. Taratibu are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of **The Medical Profession Act, 1981**, S.S. 1980-81 c. M-10.1 and/or bylaw 8.1(b)(ix) and/or bylaw 8.1(b)(xi) and/or bylaw 7.1 and/or bylaw 23.1(g) and paragraph 19 of the *Code of Ethics* contained in bylaw 7.1.
>
> The evidence that will be led in support of this charge will include the following:
>
> a) You formerly practiced in a medical clinic in Saskatoon, Saskatchewan (hereafter called "the clinic");
> b) You closed the clinic and ceased practicing in Saskatchewan on or about the October 19th, 2015;
> c) You failed to provide appropriate notice to your patients that you intended to close the clinic and cease practicing in Saskatoon;
> d) You failed to make appropriate arrangements to allow your patients to seek medical care from another health care provider;
> e) You failed to provide continuity of care for patients for whom you had provided care at the clinic;
> f) You failed to make appropriate arrangements for access to your patient records;

g) You failed to make appropriate arrangements for the transfer of your patient records:

h) You failed to make appropriate arrangements for the security of your patient records.

The Council of the College of Physicians and Surgeons directs that, pursuant to section 47.6 of **The Medical Profession Act, 1981**, the Discipline Committee hear the following charge against Dr. Mozwa Taratibu, namely:

You Dr. Mozwa Taratibu are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of **The Medical Profession Act, 1981**, S.S. 1980-81 c. M-10.1 and/or bylaw 16.1 and/or bylaw 16.2 of the bylaws of the College of Physicians and Surgeons.

The evidence that will be led in support of this charge will include the following:

a) You failed to reply to the Registrar, Dr. Shaw, within 14 days of her communication of November 26th, 2015.

b) That the address to which the letter was sent, was accessed and used by you since November 26th, 2015.

c) That the foregoing failure to reply by you to the Registrar was made after numerous attempts by the College to illicit a response went unanswered.

Pursuant to Section 57(5) of *The Medical Profession Act, 1981,* SS 1980-81, c M-10.1, Affidavits of Service of the Notice of Hearing pursuant to an Order for substitutional service were filed.

Dr. Taratibu was not represented and did not attend the hearing. In accordance with Section 58 of *The Medical Profession Act, 1981*, the hearing proceeded in Dr. Taratibu's absence.

II. EVIDENCE

Three witnesses testified at the hearing.

1. **Mr. Glen Grismer**, the Executive Director of Saskatoon Mennonite Care Services at Bethany Manor in Saskatoon testified that Bethany Manor, a senior's facility, has approximately 400 residents, the average age of whom is 84. The facility includes a medical clinic which was, for more than 4 ½ years, rented to Dr. Taratibu by Saskatoon Mennonite Care Services. The rental agreement contained a provision requiring the tenant (Dr. Taratibu) provide medical services to the residents of Bethany Manor.

Mr. Grismer testified that he was advised of Dr. Taratibu's absence at approximately the end of October 2015. By mid to end November 2015, he learned Dr. Taratibu was not coming back. With the assistance of a solicitor he took steps to occupy Dr. Taratibu's rental space. Sometime in November 2015 a notice was posted (Exhibit C-3) on the door of the clinic advising that, as of December 1, 2015, Dr. Taratibu's office phone would no longer be answered.

Mr. Grismer arranged to have the contents of the office appraised, the office secured and Dr. Taratibu's server and paper files stored in a locked storage area in the basement at Bethany Manor. The paper records consisted of approximately 30 banker's boxes. Dr. Taratibu's staff arranged a day for patients to obtain their medical records. Mr. Grismer said most of the residents of Bethany Manor were not aware of this. Dr. Taratibu's office was simply vacated on December 1, 2015. His patient files and records remain in the custody of Bethany Manor.

Mr. Grismer said since November/December 2015 he has had constant inquiries from Bethany Manor residents regarding their medical records and future access to medical care. The residents, according to Mr. Grismer, relied on Dr. Taratibu and related well to him. He described medical services at Bethany Manor being as important to the residents as food services.

2. **Ms. Jessica Fletcher**, a medical office assistant in Dr. Taratibu's office in Bethany Manor, testified she was employed by Dr. Taratibu from June 2012 to November 30, 2015. Dr. Taratibu also employed a receptionist, Melody Musli.

On October 16, 2015 Dr. Taratibu told Ms. Fletcher he was going on vacation for one week. He texted Ms. Musli the following Sunday to advise he would be away for another week. His absence was extended week by week until the end of November 2015. On November 23, 2015 Ms. Fletcher texted Dr. Taratibu (Exhibit C-4) advising *"We just had Dr. Manzini call us and tell us that you aren't going to be in for at least six months"*.

By email the same date (Exhibit C-6) Dr. Taratibu advised Ms. Fletcher *"I think my stay away will be longer than expected. It will be appropriate to inform the public and the patients that due to unforeseen important family problems I would need a prolonged leave of absence. Meanwhile I am trying to convince colleagues to come and take over our patients but nobody seem [sic] ready nor interested. The doctors at Laurier Drive Clinic are ready to see patients who will go there. Emergency INR and other results can be directed to Dr. Manzini. ..."*

Ms. Fletcher responded by email stating *"... We have many patients getting really mad at us and yelling at us on the phone. Also lots of the patients are finding new family doctors. There are bills here overdue that need to get paid that they keep phoning for. ... Another thing is, I do not know if you have talked to the College of Physicians but they keep calling here saying that they are getting many calls from patients and other doctors about you being away. ..."* Ms. Fletcher testified that Dr. Taratibu called on November 27, 2015 to advise that November 30, 2015 would be the last day of work for the staff.

As a result of a call to the College of Physicians and Surgeons Ms. Fletcher and her colleague printed approximately 100 patient charts over the next day and a half for patients to retrieve. She said the clinic had over 500 patients. All charts after mid-2012 were computerized and paper charts (stored in the basement) had all been entered into the computer.

Ms. Fletcher stated diagnostic tests and investigative reports were received daily at the clinic. These were entered in the patient's charts and forwarded electronically to Dr. Taratibu. To her knowledge they were not being reviewed by Dr. Taratibu.

Because she was not apprised of Dr. Taratibu's intentions, patients scheduled for appointments were rescheduled by her throughout the month of October 2015 and the clinic remained open until November 30, 2015.

No arrangements were made for transfer of patient records other than the day and a half noted earlier. Ms. Fletcher testified no direction was received from Dr. Taratibu regarding transfer of records, securing patient records or making copies of patient records to forward to patients. Ms. Fletcher received no instruction from Dr. Taratibu regarding what to do with the electronic back-up.

Staff were paid until the end of November by e-transfer. After that date they had no further contact with Dr. Taratibu.

3. **Ms. Susan Robinson**, Executive Assistant to the Registrar and Council of the College of Physicians and Surgeons, testified that Dr. Taratibu was registered with the College annually since 2007. In November 2015 he renewed his registration online.

Correspondence from the CPSS Regulatory Services Coordinator, Ms. Tracy Hastings, was forwarded to Dr. Taratibu on November 17, 2015 (Exhibit C-7, Tab 7) advising that the CPSS had received notification of his office being closed and requesting information as to the date of clinic closure and "what measures have been taken for patient continuity of care". Follow-up correspondence was forwarded on November 19, 2015 to Dr. Taratibu (Exhibit C-7, Tab 8).

On November 25, 2015 Dr. Taratibu responded advising that because of "important family problems to resolve abroad" he was taking a "prolonged vacation" and that doctors at the Laurier Drive Clinic had agreed to accommodate his patients and review urgent INR, etc. Further that he was looking for a doctor to replace him at the Pinehouse Clinic (Exhibit C-7, Tab 9).

On November 26, 2015 CPSS sent an email to Dr. Taratibu advising that physicians at the Laurier Drive Clinic were not aware of any arrangements having been made with Dr. Taratibu to take over care of his patients or to review laboratory results/investigations (Exhibit C-7, Tab 10).

This was followed by an email from the Registrar, Dr. Shaw, dated November 26, 2015 requesting Dr. Taratibu's response within 14 days regarding arrangements made for the care of his patients, review of investigations and consultation reports and steps taken to ensure patients were given access to their medical records. She warned that failure to comply with these requests may be viewed as abandonment of his patients and result in formal disciplinary proceedings (Exhibit C-7, Tab 11). No response was received to this communication.

III. ANALYSIS

Subsections 46(o) and (p) of the *Medical Profession Act, 1981*, SS 1980-81, c M-10.1 read as follows:

> **Charges**
> 46 Without restricting the generality of "unbecoming, improper, unprofessional or discreditable conduct", a person whose name is entered on a register is guilty of unbecoming, improper, unprofessional or discreditable conduct, if he or she:
>
> ...
>
> (o) does or fails to do any act or thing where the discipline hearing committee considers that action or failure to be unbecoming, improper, unprofessional or discreditable;
>
> (p) does or fails to do any act or thing where the council has, by bylaw, defined that act or failure to be unbecoming, improper, unprofessional or discreditable.

Both charges against Dr. Taratibu reference these subsections (see above).

The first charge also cites CPSS Bylaw 8.1(b)(ix) and (xi), 7.1 and 23.1(g) as well as Paragraph 19 of the Code of Ethics contained in Bylaw 7.1.

Bylaw 8.1 titled *Defining Unbecoming, Improper, Unprofessional or Discreditable Conduct* defines such conduct as, among other things:

> 8.1(b)(ix) Failing to maintain the standard of practice of the profession.
>
> ...
>
> (xi) Failing to continue to provide professional services to a patient until the services are no longer required or until the patient has had a reasonable opportunity to arrange for the services of another physician.

Bylaw 23.1(g) provides:

(g) A member who ceases to practise shall:

(i) transfer the records to a member with the same address and telephone number; or

(ii) transfer the records to:

1. another member practicing in the locality; or

2. a medical records department of a health care facility; or

3. a secure storage area with a person designated to allow physicians and patients reasonable access to the records,

after publication of a newspaper advertisement indicating when the transfer will take place.

Paragraph 19 of the Code of Ethics under the heading *Initiating and Dissolving a Patient-Physician Relationship* states:

> 19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted, until another suitable physician has assumed responsibility for the patient, or until the patient has been given adequate notice that you intend to terminate the relationship.

There can be no doubt that, whether or not Dr. Taratibu intended to resume his practice after leaving on holidays in October 2015, he effectively ceased practicing in Saskatchewan on October 19, 2015. When it became apparent that he would not be returning, he failed to provide his patients with notice of this or his staff with instructions as to notice to patients or arrangements for patients to retrieve their records. Furthermore, he failed to provide continuity of care for his patients by making arrangements for alternate physician or healthcare provider services for his patients.

The evidence presented both orally and in writing demonstrated that Dr. Taratibu's patients were left bewildered and uninformed. They naturally turned to Dr. Taratibu's staff, sometimes angrily, for answers. Mr. Grismer, the Executive Director of Bethany Manor, was besieged by calls from residents who were patients of Dr. Taratibu's. Neither he nor Dr. Taratibu's staff were given any indication from Dr. Taratibu as to when, or indeed if, he would be returning to practice.

The text messages sent by Ms. Fletcher (Exhibit C-4) on November 16th, 20th, 23rd, 24th and her email of November 23, 2015 to Dr. Taratibu went unanswered except for a brief text on November 25th and an email of November 26th, 2015. On November 23, 2015 Ms. Fletcher texted Dr. Taratibu advising of a call from Dr. Manzini stating Dr. Taratibu would not be back for at least six months. In a follow-up text she asked for direction from Dr. Taratibu about patients calling for test results, etc. On November 24, 2015 she texted Dr. Taratibu saying *"... This whole situation has been really stressful on Melody and myself ..."* and asking when he wanted them to stop coming into the clinic to work. The evidence is that at some time in November 2015, apparently on their own initiative, staff placed a notice on the door of the clinic announcing closure until further notice "as there is no medical doctor" (Exhibit C-3). CPSS learned that Dr. Manzini and his colleagues at the Laurier Clinic had not entered into an arrangement with Dr. Taratibu for the care of his patients.

No evidence was provided by Dr. Taratibu or anyone on his behalf contradicting the evidence that he failed to provide appropriate notice to his patients or to make appropriate arrangements for them to receive alternative medical care. In the absence of such evidence or any explanation from Dr. Taratibu we are satisfied that his conduct contravenes By-law 8.1(b)(ix) and (xi) as well as Paragraph 19 of the Code of Ethics.

With respect to the aspect of Charge #1 dealing with patient records, Ms. Fletcher testified that she and the other staff member provided, for one and a half days, an opportunity for Dr. Taratibu's patients to retrieve their medical records from the clinic. Again, this appears to have been an effort undertaken at the initiative of the staff without specific or any instructions from Dr. Taratibu. Mr. Grismer testified that the paper charts were and continue to be stored in the basement of Bethany Manor. Dr. Taratibu provided no instructions regarding storage or security of these records or of the server containing electronic copies of patients' medical records. Neither did Dr. Taratibu arrange for patient access to or transfer of patient records.

Bylaw 23.1(g) speaks to the issue of transfer of patient records specifically. Dr. Taratibu violated these provisions by failing to transfer or arrange for transfer of his patients' medical records to another practicing member, a medical records department of a healthcare facility or a secure storage area with a person designated to allow access to the records. Furthermore, no publication of a newspaper advertisement indicating when the transfer would take place was issued.

Counsel for the College, Mr. Mason, referred us to a decision of a previous CPSS Disciplinary Hearing Committee dated November 18, 2010 involving circumstances similar to those before us. In that case Dr. Tshabalala went on vacation to South Africa in January 2009. He was expected to return on February 10 or 11, 2009. He gave no indication prior to his departure that he was not intending to return and it was not until April that his office accepted that he would not be coming back. The facts in that case varied from those before us in that Dr. Tshabalala's clinic had "good locum coverage at the time" and "a new doctor who had just started at the clinic". Dr. Tshabalala was charged with, among other things, failing to make arrangements for his patients prior to his departure constituting a breach of Section 19 of the Code of Ethics. The Committee found him guilty of conduct unbecoming, improper, unprofessional or discredible on the grounds that, although Dr. Tshabalala, in the summer of 2008 when he appeared to be contemplating a move from Saskatchewan indicated he took into account the presence of other physicians in the community who would be available to his patients, his obligations were clearly laid out to him by the College and " *Whatever the stresses Dr. Tshabalala was under, he is a member of a profession for which higher standards are expected, and he failed to provide even minimal information to his colleagues in Leader and to the Health Region"*.

Mr. Mason also provided Minutes of a CPSS Council Meeting of 2008 recording the conviction of Dr. Werner Van Tender for leaving his practice in Kamsack, Saskatchewan on May 30, 2008 without making appropriate arrangements for follow-up care of his patients and/or arrangements for review of laboratory results and/or consultation reports for his patients. Dr.

Van Tender was disciplined at the same meeting for failing to reply to correspondence from the Deputy Registrar of the College of Physicians and Surgeons within the time allotted.

In the circumstances, we are satisfied the College has met its burden of proving, on a balance of probabilities, all aspects of Charge #1 against Dr. Taratibu.

The second charge against Dr. Taratibu (set out above) relates to his failure to reply to the Registrar of the College, Dr. Shaw, within 14 days of her communication of November 26, 2015.

CPSS Bylaws 16.1 and 16.2 provide as follows:

> **16.1 College requests for information**
> (a) The Registrar, the Deputy Registrar, the Executive Committee, the Council and the Standing Committees referred to in the bylaws of the College frequently request information and explanations from physicians. Prompt response to such requests is required if the College is to expeditiously and effectively regulate the practice of medicine and comply with the objects of the Act.
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> **16.2 Response to College Requests for Information**
> (a) Upon receipt of a written request from the Registrar, the Deputy Registrar, the Executive Committee, the Council or a standing committee for information a physician shall:
>
> (i) respond substantially to the request;
>
> (ii) provide the information or explanation requested to the best of the physician's ability to do so;
>
> (iii) provide originals of documents requested, if originals are requested, or legible copies of documents if copies are requested;
>
> (iv) provide a printed record if the requested information or documents are stored in an electronic computer storage form or similar form.
>
> (b) A physician shall provide the requested information, as referred to in the paragraph (a) within 14 days of receipt of the request, or such additional time as may be granted by the Registrar or Deputy Registrar for the response.
>
> (c) A physician who is requested to provide information to the College of Physicians and Surgeons or to any individual or committees associated with the College of Physicians and Surgeons under paragraph (a), or under any other provision of the Act or these bylaws relating to the provision of information and documents including, without limiting the generality of the foregoing, the Administrative bylaws establishing the standing committees, 4.1, 16.1, 18.1, 19.1, 21.1, 22.1, or 25.1 of the bylaws and Section 55.3 of the Act, shall provide the information, explanation or documents contemplated by the request whether the consent of any person with an interest in the information, explanation or documents has, or has not, been sought or obtained.
>
> (d) Information obtained pursuant to this paragraph or under any other provision of the Act or these bylaws relating to the provision of information and documents shall be treated confidentially and, unless otherwise directed by the Executive Committee, or the Council, shall not be used except for

> the purpose of complying with the objects of the Act or the duties of the committee or individual which obtains such information or documents.
>
> (e) It is unbecoming, improper, unprofessional or discreditable conduct for a physician to fail to comply with paragraph 16.1 or 16.2.

Through Ms. Robinson, Counsel tendered communication from the College to Dr. Taratibu dated November 17, 2015 from Tracy Hastings, Regulatory Services Coordinator, November 19, 2015 from Leslie Frey, Regulatory Services Coordinator, November 26, 2015 from Leslie Frey, November 26, 2015 from the Registrar, Dr. Karen Shaw, and December 16, 2015 and January 28, 2016 from Mr. Chris Mason, CPSS Legal Counsel. Ms. Frey's correspondence of November 19, 2015 included links to the CPSS Bylaws, applicable Policies and guidelines. Likewise attached to Dr. Shaw's correspondence of November 26, 2015 to Dr. Taratibu was the College's Guideline on Patient-Physician Relationships, the Leaving Practice Guide and Bylaw 23 pertaining to medical records.

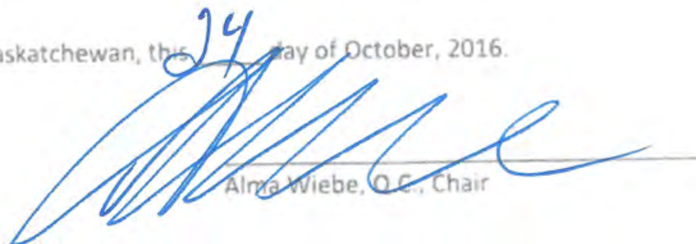
In response to these various communications, Dr. Taratibu, on November 25, 2015 sent the email referred to on page 5 above to Ms. Amanda Nelson, CPSS Staff. On November 30, 2015 Dr. Taratibu renewed his annual registration with CPSS online. In response to Mr. Mason's correspondence of December 16, 2015, Dr. Taratibu, on January 5, 2016, requested an extension of time in which to respond. This was granted by Mr. Mason, extending Dr. Taratibu's response time to January 20, 2016. No further communication was received by the College from Dr. Taratibu thereafter.

We are satisfied, based on the evidence, that Dr. Taratibu received the College's communication and failed to respond. Accordingly, he is guilty of violating CPSS Bylaw 16.2(b) which, pursuant to Bylaw 16.2(e) constitutes unbecoming, improper, unprofessional or discreditable conduce and we so find.

We were not asked to make recommendations as to penalty in this case and do not do so.

In closing, we wish to thank counsel for the College for his able and professional presentation of the evidence and submissions in this matter.

DATED at Saskatoon, Saskatchewan, this 24 day of October, 2016.

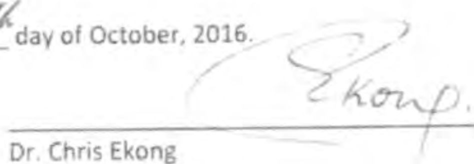


Alma Wiebe, Q.C., Chair

DATED at Prince Albert, Saskatchewan, this 25th day of October, 2016.

Dr. Louis Coertze

DATED at Regina, Saskatchewan, this 19th day of October, 2016.



Dr. Chris Ekong

IN THE MATTER OF *THE MEDICAL PROFESSION ACT, 1981*, SS 1980-81, cM-10.1.

PENALTY HEARING FOR DR MOZWA TARATIBU

FRIDAY 18 NOVEMBER, 2016

Mr. Chris Mason appearing for the College of Physicians and Surgeons of Saskatchewan

No-one appearing for Dr Mozwa Taratibu

THE CHARGES:

1) *You Dr. Taratibu are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of Section 46(o) and/or section 46(p) of* ***The Medical Profession Act, 1981*** *S.S. 1980-81 c. M-10.1 and/or bylaw 8.1(b)(ix) and/or bylaw 8.1(b)(xi) and/or bylaw 7.1 and/or bylaw 23.1(g) and paragraph 19 of the Code of Ethics contained in bylaw 7.1.*

   The evidence that will be led in support of this charge will include the following:

. *a) You formerly practised in a medical clinic in Saskatoon, Saskatchewan (hereafter called "the clinic");*
. *b) You closed the clinic and ceased practising in Saskatchewan on or about the October 19, 2015;*
. *c) You failed to provide appropriate notice to your patients that you intended to close the clinic and cease practising in Saskatoon;*
. *d) You failed to make appropriate arrangements to allow your patients to seek medical care from another health care provider;*
. *e) You failed to provide continuity of care for patients for whom you had provided care at the clinic;*
. *f) You failed to make appropriate arrangements for access to your patient records;*
. *g) You failed to make appropriate arrangements for the transfer of your patient records;*
. *h) You failed to make appropriate arrangements for the security of your patient records*

2) *You Dr. Mozwa Taratibu are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or section 46(p) of **The Medical Profession Act, 1981** s.s. 1980-81 c. M-10.1, and/or bylaw 16.1 and/or bylaw 16.2 of the bylaws of the College of Physicians and Surgeons.*

The evidence to be led in support of this charge will include the following:

. *a) You failed to reply to the Registrar, Dr. Shaw, within 14 days of her communication of November 26, 2015.*
. *b) That the address to which the letter was sent, was accessed and used by you since November 26, 2015.*
. *c) That this foregoing failure to reply by you to the Registrar was made after numerous attempts by the College to elicit a response went unanswered.*

Submissions were made by Mr. Chris Mason on behalf of the Registrar's Office. Dr. Taratibu did not retain legal counsel and did not attend the Penalty Hearing.

THE REGISTRAR'S POSITION ON PENALTY

The Registrars position is that the proposed fines and penalties related to charge #1 is appropriate to address the specific conduct with which Dr. Taratibu has been found guilty.

. A) That the penalty is consistent and within the range imposed upon other physicians.
. B) That Dr. Taratibu failed to cooperate at any point in the process, an aggravating factor.
. C) That Dr. Taratibu's conduct of failing to cooperate with both the College as well as his clinic staff and the patients had significant aggravating consequences for the resolution of the allegations but more importantly to the public at large as the personal health information of patients, many of which are well over the age of 75, are still in abeyance.
. D) That Dr. Taratibu is currently registered as an ***inactive registrant*** that expires November 30 2016, consequently he cannot be suspended from the practice of medicine in Saskatchewan, and this reduces Councils options for penalty.
. E) As found on page 7 of the decision of the Discipline Hearing Committee it states: "*There can be no doubt that, whether or not Dr. Taratibu intended to resume his practice after leaving on holidays in October 2015, he effectively ceased practicing in Saskatchewan on October 19,*

2015. When it became apparent that he would not be returning, he failed to provide his patients with notice of this or his staff with instructions as to notice to patients or arrangements for patients to retrieve their records. Furthermore, he failed to provide continuity of care for his patients by making arrangements for alternate physician or healthcare provider services for his patients."

A fine of $15,000.00 and the successful completion of a professional ethics course is reasonable to address Dr. Taratibu's conduct with which he has been found guilty.

The Registrar's position is that the proposed fines and penalties related to charge #2 is appropriate to address the specific conduct with which Dr. Taratibu has been found guilty:

. A) That the penalty is consistent within a reasonable range imposed upon other physicians.
. B) That Dr. Taratibu failed to cooperate at any point in the process, an aggravating factor. As noted on page 11 of the decision after renewing his annual registration online and being granted an extension to reply to Mr. Mason, *"No further communication was received by the College from Dr. Taratibu thereafter."*
. C) That Dr. Taratibu has never substantively responded to the either the College or the Registrar despite being contacted several times by the College.
. D) As found on page 11 of the decision: "*We are satisfied, based on the evidence, that Dr. Taratibu received the College's communication and failed to respond."*

A fine of $2,500.00 is reasonable to address Dr. Taratibu's conduct with which his has been found guilty. The nature of this matter is more egregious given the facts found by the Discipline Hearing Committee. Specifically Dr. Taratibu was well aware of the significant problems he caused when he abandoned his practice and was then emailed with a request from Dr. Shaw to address this serious problem which he ignored. It is not unreasonable to request a higher fine in this matter given the committee's findings of a fine of $2,500.00.

PRINCIPLES IN IMPOSING PENALTY

The factors which are frequently considered in imposing an appropriate penalty are outlined in **Camgoz v. College of Physicians and Surgeons** (1993), 114 Sask. R. 161 (Q.B.) at 173-174. Although these factors were discussed in the context of sexual abuse of a patient, similar considerations

have been used in other disciplinary matters (discussed below):

a) the nature and gravity of the proven allegations;
b) the age of the offending physician;
c) the age of the offended patient;
d) evidence of the frequency of the commission of the particular acts of misconduct within particularly, and without generally, the Province;
e) the presence or absence of mitigating circumstances, if any;
f) specific deterrence;
g) general deterrence;
h) previous record, if any, for the same or similar misconduct,
i) the length of time that has elapsed between the date of any previous misconduct and conviction thereon, and, the member's (properly considered) conduct since that time;
j) ensuring that the penalty imposed will, as mandated by s. 69.1 of the Act, protect the public and ensure the safe and proper practice of medicine;
k) the need to maintain the public's confidence in the integrity of the respondent's ability to properly supervise the professional conduct of its members;
l) ensuring that the penalty imposed is not disparate with penalties previously imposed in this jurisdiction in particular, and in other jurisdictions in general, for the same or similar act of misconduct.

The court in **Pottie** v. **Nova Scotia Real Estate Commission** [2005] N.S.J. No. 276 (S.C.) set out a number of principles that the court felt would provide guidance to the commission in assessing penalties against its members. The court stated that:

> *58 The Commission's counsel requested the Court to provide some guidance to the Commission. Because it is the Commission itself that has the expertise to determine what is in the best interests of the public when dealing with its members, it is not appropriate for a Court to give directions that may fetter the exercise of the discretion given to the Commission to set standards and enforce them*
> *59 The imposition of sanctions is not a mechanical exercise. While it is not improper for a Discipline Committee to take into account informal rules or guidelines and previous decisions for which written reasons have been given - all of which increase certainty, reduce inconsistency and raise the level of accountability to the public - the Discipline Committee must treat each case according to its own circumstances; that is, in accordance with the nature of the offence and the unique circumstances of the offender. It must not feel bound to automatically follow a rule, policy, guideline or*

precedent.
60 While proceedings before the Discipline Committee are not criminal, but rather civil, the object of the imposition of sanctions resulting from breaches of the Act or of professional misconduct are not dissimilar to the purpose and principles of sentencing contained in the Criminal Code beginning with s. 718, 718.1 and 718.2. The principles of sentencing in the criminal context reflect the requirement to protect the public by the denunciation of unlawful conduct, specific deterrence, general deterrence, rehabilitation, and the promotion of a sense of responsibility by the offender.
61 The process of sentencing requires the decision maker to consider the particular gravity of the offence itself and the degree of responsibility of the offender. In respect of both of these factors there may be aggravating or mitigating circumstances.
62 While the criminal law clearly prohibits a "cookie cutter" approach to sentencing, it is a factor that, in similar circumstances involving similar offences and similar offenders, consideration of precedent is one factor that promotes fairness, certainty and consistency.
63 Without intending in any way to restrict or direct the redetermination to be made by the Committee in the case at bar, it is relevant for the Committee to consider not only the seriousness of the offence itself (which its decision stated it had), but also the factors related to the appellant himself. Is he a first time offender? Is he a person with a long record of good behaviour who can provide a logical and credible explanation for this glitch in his behaviour? These may constitute mitigating factors. On the other hand, if the offender has extensive business experience, does not have a long record of good behaviour, and has no credible excuse (such as an some unusual personal crisis that is unlikely to be repeated), then these may constitute aggravating factors.
64 With regards to the offence itself, offences of the nature that adversely affect the public, or are deliberate (as opposed to negligent or careless) might be aggravating factors. Certainly the seriousness of the offence is an aggravating factor.
The nature and gravity of the proven allegations The age and experience of the offender
The previous character of the offender and in particular the presence or absence of any prior complaints or convictions
The age and circumstances of the victim (if there was one)
The number of times the offence was proven to have occurred
The role of the offender in acknowledging what had occurred
Whether the offender had already suffered other serious financial or other penalties as a result of the allegations having been made
The impact of the incident on the victim (if there was one) The presence or absence of any mitigating circumstances

The need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper conduct of the real estate profession
The need to maintain the public's confidence in the integrity of the real estate profession
The degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct
The range of sentence in other similar cases

PREVIOUS PENALTIES FOR SIMILAR CONDUCT

One of the principles in assessing penalty is that the penalties imposed upon individuals who have committed similar acts of unprofessional conduct should be treated similarly. There will of course be a variation depending upon how the other factors relevant to penalty apply.

Previous penalties of similar conduct related to charge #1 is as follows:

One parallel case is that of **Dr. Von Tonder** whom over 8.5 years ago in May of 2008 and who no longer resided in Saskatchewan, was sanctioned $10,000 after pleading guilty to failing to:

a. make appropriate arrangements for follow up care of patients;
b. make appropriate arrangements for review of test and reports he ordered; and
c. make appropriate arrangements for ongoing care of patients in hospital under his care.

Additionally Dr. Van Tonder had a fine of $1,500.00 imposed upon him for failing to reply to the Deputy Registrar within 14 days or respond substantially and/or provide an explanation.

A second case that parallels this one involves the matter of **Dr. Goldstuck** of Alberta. CPSA learned that he abandoned his practice resulting in the College taking steps to:

- take custody of his office.
- rekey the locks;
- secure drugs;
- make arrangements for records management; and
- a nearby primary care network agreed to manage his patients.

These additional onerous steps were made in this matter however it was

Bethany Manor and their management that made these arrangements.

The penalty in the Dr. Goldstuck matter found:

- He was assessed the full costs of the hearing /investigation of $15,516.38
- Fined $40,000.00 to pay for the archiving of his charts; and
- License to practice is suspended if the fines/cost are not paid within a reasonable time.

Previous penalties for similar conduct related to charge #2 are as follows:

- Recently Dr. Schoeman was ultimately cooperative and admitted unprofessional conduct and was fined $1,500 based upon a joint submission.

- Additionally, Dr. Rieder admitted unprofessional conduct and was fined $1,500 based upon a joint submission.

- In 2014 Dr. Malik admitted similar unprofessional conduct and was fined $1,500.

Prior to Dr. Malik, Council dealt with a sequence of charges against Dr. Bruce Zimmerman related to his failure to respond to College correspondence. In 2005 a second subsequent penalty on Dr. Zimmermann for failing to respond to College correspondence was a fine of $1,500 on each of the three charges of unprofessional conduct.

The following penalty was imposed by Council:

THE PENALTY

The Council of the College of Physicians and Surgeons imposes the following penalty on Dr. Mozwa Taratibu pursuant to The Medical Profession Act, 1981:

1. Pursuant to section 54(1)(e) of The Medical Profession Act, 1981, Council imposes a reprimand upon Dr. Taratibu.
2. With respect to the finding of guilt on charge #1 and pursuant to Section 54(1)(f) of The Medical Profession Act, 1981, Council imposes a fine of $15,000 on Dr. Taratibu, payable forthwith.
3. With respect to the finding of guilt on charge #2 and pursuant to Section 54(1)(f) of The Medical Profession Act, 1981, Council imposes a fine of

$2,500 on Dr. Taratibu, payable forthwith.

4. Pursuant to section 54(1)(g) of The Medical Profession Act, 1981, Council imposes that Dr. Taratibu successfully complete an ethics course on professionalism to the satisfaction of the Registrar. Such course shall be completed not later than May 15th, 2017. The programs "Medical Ethics, Boundaries and Professionalism" by Case Western Reserve University, "Probe Program" by CPEP and "Medical Ethics and Professionalism" by Professional Boundaries Inc., are ethics programs acceptable to the Registrar.

5. Pursuant to section 54(1)(i) of The Medical Profession Act, 1981, the Council directs Dr. Taratibu to pay the costs of and incidental to the investigation and hearing in the amount of $ 20,043.08. Such payment shall be made in full by December 31, 2016.

6. Pursuant to section 54(1)(g) of The Medical Profession Act, 1981, the Council directs that Dr. Taratibu will be suspended from the privileges of a duly qualified medical practitioner if he fails to complete the ethics course on professionalism as required and will remain suspended until he successfully completes that course.

7. Pursuant to section 54(2) if Dr. Taratibu should fail to pay the costs as required by paragraph 5, Dr. Taratibu's licence shall be suspended until the costs are paid in full.

8. Council reserves the right to amend the terms of this order by extending the time for payment of the costs, by arranging for the payment of costs over time or by installments, or by reducing or forgiving the payment of the costs and, in the event of such an amendment, the Council may impose such additional conditions pertaining to payment and suspension of Dr. Taratibu's license for the non-payment as may be permitted by The Medical Profession Act, 1981.

REASONS FOR THE DECISION

Council took note of the fact that there were no formal submissions from Dr. Taratibu.

The facts and the determination of unprofessional conduct have been established by the Discipline Hearing Committee. The College has provided an appropriate penalty for the proved conduct. The discipline hearing, as well as the penalty hearing proceeded *in absentia* of Dr. Taratibu. Council deliberated in camera and followed the above-mentioned principles and reached a decision unanimously. Mitigating factors as well as aggravating factors were discussed but none were found to be applicable.

Accepted by Council of the College of Physicians and Surgeons:
25 March, 2017