NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Alan Taniguchi, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of patients referred to orally or in the exhibits filed at the hearing, under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: **Ontario (College of Physicians and Surgeons of Ontario) v. Taniguchi,**
2019 ONCPSD 24

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the ***Regulated Health Professions Act, 1991***, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. ALAN TANIGUCHI

PANEL MEMBERS:

MR. JOHN LANGS
DR. PAMELA CHART
MS. CHRISTINE TEBBUTT
DR. ELIZABETH SAMSON
DR. SUSANNA YANIVKER

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. EMILY GRAHAM

COUNSEL FOR DR. TANIGUCHI:

MS. KEARY GRACE
MS. JESSICA LAHAM

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. JENNIFER MCALEER

PUBLICATION BAN

Hearing Date: **May 10, 2019**
Decision Date: **May 10, 2019**
Written Decision Date: **June 24, 2019**

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on May 10, 2019. At the conclusion of the hearing, the Committee released a written order stating its finding that Dr. Taniguchi committed an act of professional misconduct, and setting out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Alan Taniguchi committed an act of professional misconduct:

i. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and

ii. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*("O. Reg. 856/93"), in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Taniguchi was incompetent as defined in subsection 52(1) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18, as amended (the "Code").

RESPONSE TO THE ALLEGATIONS

Dr. Taniguchi admitted the allegations in the Notice of Hearing that he failed to maintain the standard of practice of the profession, and engaged in conduct or an act or omission relevant to

the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The College withdrew the allegation of incompetence.

PART I – FACTS

The following facts were set out in an Agreed Statement of Facts and Admission (Liability), which was filed as an exhibit and presented to the Committee:

A. Background

1. Dr. Taniguchi is 54 years old. He received his certificate of registration authorizing independent practice in 1991. He practices in Hamilton, Ontario in the area of palliative care. He previously also practiced in the area of long-term care medicine.

2. In addition to his clinical practice, Dr. Taniguchi is an Assistant Clinical Professor at McMaster University, and the Program Director of McMaster's Family Medicine Palliative Care Residency Program. At the time of the events at issue, in addition to his clinical duties, Dr. Taniguchi had significant teaching, academic, and administrative responsibilities.

B. Failure to comply with SCERP

3. On July 15, 2016, the Quality Assurance Committee of the College of Physicians and Surgeons of Ontario ("the College") required Dr. Taniguchi to participate in a specified continuing education or remediation program ("SCERP") consisting of:

a) a review and written summary of a College policy, and a section of the Practice Guide;

b) a period of clinical supervision, in which Dr. Taniguchi was required to meet with a supervisor monthly for six months and review 10 charts at each meeting; and

c) a reassessment of his practice.

4. Dr. Taniguchi was notified of the Committee's decision on August 5, 2016. He was required to retain a clinical supervisor within 30 days of receiving the decision.

5. Dr. Taniguchi did not retain a clinical supervisor, or undergo a reassessment, pursuant to the SCERP.

6. Dr. Taniguchi failed to respond to correspondence from the College on August 16, 2016, November 22, 2016 and January 2, 2017 with respect to his compliance with the SCERP.

7. Dr. Taniguchi submitted the required written summary on June 23, 2017.

C. Breach of Order

8. On May 10, 2017, the QAC made an Order imposing terms, conditions, and limitations on Dr. Taniguchi's certificate of registration. Under the Order, Dr. Taniguchi was required to obtain a clinical supervisor acceptable to the College within 14 days of the Order, and meet with the clinical supervisor monthly to review 10 long-term care patient charts. The Order was to remain in effect until May 9, 2018. If Dr. Taniguchi was unable to retain a clinical supervisor as required by the Order, he was required to cease practising long-term care until such time as he had done so.

9. On May 25, 2017, Dr. Taniguchi proposed that Dr. David Chan be approved as his supervisor. On May 31, 2017, the College confirmed that Dr. Chan was approved. On June 7, 2017, the College advised Dr. Taniguchi that it had received Dr. Chan's executed undertaking, and that Dr. Taniguchi was permitted to return to practice.

10. Dr. Taniguchi had his first and only meeting with Dr. Chan on September 8, 2017. As Dr. Chan noted in his report of that meeting, attached at Tab 1 [to the Agreed Statement of Facts and Admission (Liability)]:

a) there were "no deficiencies identified" in Dr. Taniguchi's charts; and

b) "Dr. Taniguchi has made a lot of progress. His documentation is excellent and in my opinion meets the standard of documentation in a [long-term care] setting."

11. Although Dr. Chan's initial report was favourable, Dr. Taniguchi states that he felt overwhelmed. He failed to arrange follow-up meetings with Dr. Chan. Dr. Chan emailed Dr.

Taniguchi twice after their first meeting to encourage Dr. Taniguchi to schedule their next meeting, but Dr. Taniguchi did not respond.

12. On January 26, 2018, Dr. Taniguchi was notified that he was in breach of the Order, and was advised to meet with Dr. Chan and review 40 charts with him by February 8, 2018 to bring himself back into compliance. Dr. Taniguchi failed to do so.

13. On February 12, 2018, Dr. Chan advised the College that he had not heard from Dr. Taniguchi, and withdrew as Dr. Taniguchi's clinical supervisor. Dr. Taniguchi ceased practising long-term care in February 2018.

D. Section 75 Investigation

14. In addition to making the Order described above, the QAC also disclosed to the ICRC Dr. Taniguchi's name, as well as the allegations that he may have committed an act of professional misconduct, including but not limited to lack of governability, or that he may be incompetent or incapacitated. The Registrar appointed investigators to investigate whether Dr. Taniguchi, in his general medicine practice, including long-term care and palliative care, had engaged in professional misconduct or was incompetent.

15. Dr. Taniguchi was notified of the investigation on July 13, 2017. The investigator asked Dr. Taniguchi to complete a Physician Practice Questionnaire and an Electronic Records Questionnaire, and return them to the College within 10 business days. Dr. Taniguchi did not respond. The investigator sent several further requests for Dr. Taniguchi's completed questionnaires between October 2017 and February 2018, to which Dr. Taniguchi did not respond. The College did not receive Dr. Taniguchi's completed questionnaires.

16. The College retained Dr. Benoit Robert to opine on Dr. Taniguchi's care of 25 patients in both palliative care and long-term care practices.

17. On April 16, 2018, the investigator wrote to Dr. Taniguchi advising him that Dr. Robert had requested to interview Dr. Taniguchi for the purposes of preparing his opinion. Dr. Taniguchi did not respond to this letter, and did not attend for an interview with Dr. Robert. Dr. Robert's report is attached at Tab 2 [to the Agreed Statement of Facts and Admission

(Liability)].

18. With respect to Dr. Taniguchi's palliative care practice, Dr. Robert opined:

    a) Dr. Taniguchi's pattern of documentation was consistent with a physician who practiced "at a distance". It was unclear from much of the documentation provided whether Dr. Taniguchi had direct contact with patients. Although Dr. Taniguchi was a consultant in a teaching setting, his charting pattern was suggestive of not being available on a consistent basis;

    b) Dr. Taniguchi's documentation of encounters did not follow a "SOAP" format, or a problem-based approach. His notes contained minimal subjective and objective data, and his assessments and plans were cursory. There was limited evidence of physical examinations;

    c) Dr. Taniguchi demonstrated a significant lack of knowledge of appropriate documentation. The paucity of charting and documentation interfered with Dr. Robert's ability to opine on Dr. Taniguchi's knowledge with respect to palliative care. The lack of documentation also precluded an accurate assessment of Dr. Taniguchi's skill; and

    d) Dr. Taniguchi was not readily available to assess patients in a timely fashion. While Dr. Taniguchi's clinical practice was unlikely to expose patients to harm or injury, this was due to the rapid available backup by other qualified palliative care physicians on days on which Dr. Taniguchi is not available.

19. With respect to Dr. Taniguchi's long-term care practice, Dr. Robert opined:

    a) It was not clear from Dr. Taniguchi's documentation in 2015 and 2016 that he was performing admission physicals, nor was it clear that he was performing annual physicals. There were a number of occasions on which these physicals were not documented. Dr. Taniguchi's extensive use of PRN orders in the order sets in some charts also suggested that his approach to those residents' care was not personalized;

    b) There was a significant improvement in Dr. Taniguchi's long-term care documentation after mid-2017, with respect to his use of SOAP notes, and the

documentation of admission and annual exams, and care conferences;

c) Dr. Taniguchi's knowledge and skill were difficult to ascertain from his charts. However, there were instances in which Dr. Taniguchi's charting suggested a lack of knowledge and/or skill. In one case, Dr. Taniguchi failed to follow through on a psychiatry note outlining the need for quarterly monitoring of the patient's liver function tests. In another case, Dr. Taniguchi failed to address rising creatinine levels in an elderly patient who was prescribed Ramipril, and who later developed acute-on-chronic renal failure; and

d) Dr. Taniguchi was not readily available to assess his patient load, and his lack of availability was concerning. His practice of attending on patients only every two weeks allowed for conditions to aggravate between visits. It also appeared that he was not available between visits. The use of email did not seem to expedite communication. It also was not clear that the email channels used were secure, and Dr. Taniguchi's email correspondence at times comingled patients' personal health information.

E. Section 25.4 Order

20. On November 8, 2018, the Inquiries, Complaints and Reports Committee made an Order under s. 25.4 of the Health Professions Procedural Code ("s. 25.4 Order"), requiring, among other things, that Dr. Taniguchi practice under the guidance of a clinical supervisor.

21. On November 23, 2018, Dr. Anne Woods was approved as Dr. Taniguchi's clinical supervisor. Since that time, Dr. Taniguchi has been fully cooperative with the College, and has been meeting with Dr. Woods on a regular basis to review patient charts from his palliative care practice pursuant to the s. 25.4 Order. Dr. Woods's reports have been positive, and indicate that Dr. Taniguchi's care has been appropriate.

22. As Dr. Woods has noted in her reports, attached at Tab 3 [to the Agreed Statement of Facts and Admission (Liability)]:

a) "Once aware of the requirements for charting, Dr. Taniguchi's notes have met all

requirements, have addressed concerns raised in the previous audit, and reflect a care that is exemplary. I have made only one recommendation: "Ensure the documented physical exam reflects all major concerns noted as issues that day".

b) "Dr. Taniguchi's notes consistently reflect a high quality of care, supervision, education, collegiality, and graciousness"; and

c) "Dr. Taniguchi has the reputation in the wider palliative medicine community as being the doctor's doctor, the one physicians would choose to have look after them. He is known for his unremitting respect for other physicians, his knowledge, and his hard work".

PART II – ADMISSION

23. Dr. Taniguchi admits the facts at paragraphs 1 to 22 above, and admits that, based on these facts, he engaged in professional misconduct under:

a) paragraph 1(1)2 of Ontario Regulation 856/93 made under the Medicine Act, 1991, in that he failed to maintain the standard of practice of the profession; and

b) paragraph 1(1)33 of O Reg. 856/93, in that he engaged conduct or an act or omission relevant to the practice of medicine that would be regarded by members as disgraceful, dishonourable or unprofessional.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission (Liability). Having regard to these facts, the Committee found that Dr. Taniguchi committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession, and engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

AGREED STATEMENT OF FACTS ON PENALTY

The following facts were set out in the Agreed Statement of Facts on Penalty, which was filed as an exhibit at the hearing and presented to the Committee:

A. Steps Dr. Taniguchi has taken to address his conduct

1. Dr. Taniguchi states that, between 2016 and 2018, he was feeling overwhelmed by his professional responsibilities, and was struggling to cope, and that this contributed to his failure to comply with the SCERP, and his failure to be responsive to the College.

2. In order to address the issues that contributed to his conduct in this case, Dr. Taniguchi is working to reorganize his workload. He has stepped down from some of his academic responsibilities, and has recently moved to a lower-volume clinical environment. Dr. Taniguchi has also seen a counsellor to help him develop his stress management and coping skills.

B. Undertaking

3. On May 8, 2019, Dr. Taniguchi entered into an undertaking with the College by which he agreed to, among other things:

a) practise under the guidance of a Clinical Supervisor acceptable to the College for 6 months;

b) engage in professional education in professional responsibilities in post-graduate medical education, and medical ethics; and

c) undergo a reassessment of his practice by an assessor selected by the College within 6 months of the end of the period of Clinical Supervision.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The parties jointly proposed that Dr. Taniguchi appear before the panel to be reprimanded; that his certificate of registration be suspended for a period of 2 months; and that he pay costs to the College in the amount of $6,000.00

The Committee is aware that when there is a joint submission on penalty, a tribunal or court should not depart from the proposed penalty unless it would bring the administration of justice into disrepute or is otherwise contrary to the public interest (*R v. Anthony-Cook*, 2016 SCC 43).

The Committee is also aware of the accepted principles that guide the determination of an appropriate penalty. First and foremost, the penalty must protect the public. The penalty should also provide both specific deterrence to the member and general deterrence to the profession. In addition, the penalty is to reflect the profession's disapproval of the misconduct and maintain public confidence in the College's ability to regulate the profession in the public interest. Where appropriate, the penalty should also provide for the rehabilitation of the member.

Aggravating Factors

Disgraceful, dishonourable or unprofessional conduct

In June 2016, the Quality Assurance Committee required that Dr. Taniguchi participate in a SCERP. Dr. Taniguchi's obligations under the SCERP required a period of supervision. Dr. Taniguchi did not retain a supervisor. Further, he failed to respond to correspondence from the College on three occasions over six months. Eventually Dr. Taniguchi fulfilled only part of the SCERP, by submitting the written summary.

In May 2017, the Quality Assurance Committee ordered clinical supervision of Dr. Taniguchi's practice for twelve months. Dr. Taniguchi met with his clinical supervisor, Dr. Chan, only once in September 2017. Even though no deficiencies were identified, Dr. Taniguchi failed to arrange follow-up meetings with Dr. Chan even though Dr. Chan emailed him on several occasions.

Early in 2018, Dr. Taniguchi was notified that he was in breach of the Order. Dr. Chan withdrew as Dr. Taniguchi's supervisor. The matter was referred to ICRC and a Section 75 Investigation was launched. Dr. Taniguchi was required to fill out questionnaires provided by the College investigator. Dr. Taniguchi did not respond to repeated requests for this information.

The above sequence of events illustrates Dr. Taniguchi's lack of respect for and cooperation with the College as his governing body. It is critical that members recognize and respect the College's

regulatory role. In order for public trust in the profession to be maintained, strict compliance by physicians with orders made by any College committee is of utmost importance.

Dr. Taniguchi's pattern of ignoring requests from the College demonstrates a serious disregard of his professional responsibility. In the Committee's view, Dr. Taniguchi's conduct is even more egregious given his teaching role.

Failure to Maintain the Standard of Practice

With respect to Dr. Taniguchi's palliative care practice, expert evidence identified documentation deficiencies and concerns regarding Dr. Taniguchi's availability to assess patients on a consistent basis.

With respect to Dr. Taniguchi's long term care practice, expert evidence identified further documentary deficiencies. For instance, it was unclear from the documentation whether Dr. Taniguchi was performing annual and/or admission physicals. Further, Dr. Taniguchi's lack of availability was also pointed to as a concern.

Medical records are valuable tools for physicians and patients alike. The medical record provides a comprehensive and detailed account of a patient's medical history, which in turn optimizes future clinical encounters. It is Dr. Taniguchi's responsibility to ensure that all patient encounters are documented.

Mitigating Factors

- Dr. Taniguchi attributed his lack of response to being overwhelmed and struggling to deal with his responsibilities.
- This is the first time Dr. Taniguchi has appeared before the Discipline Committee.
- Dr. Taniguchi admitted the allegations. This showed insight and acceptance of responsibility, and saved the college the time and expense of a contested hearing.
- Dr. Taniguchi has been fully cooperative with the November 2018 ICRC Order that requires, among other things, that he practice under the guidance of a clinical supervisor.

Case Law

In *CPSO v. Lowe*, 2015 ONCPSD 21, the Committee found that Dr. Lowe engaged in disgraceful, dishonourable or unprofessional conduct by breaching an undertaking that he was given several opportunities to comply with. The Committee was of the view that Dr. Lowe's pattern of behaviour in his interactions with the College demonstrated a lack of communication skills. A reprimand and costs payable to the College were ordered. Dr. Lowe was also ordered to reimburse the College for education sessions related to physician-patient communication rendered to him by Dr. Y. This was an agreed statement of facts case and the Committee accepted the joint proposal on penalty.

In *CPSO v. Pinto*, 2017 ONCPSD 5, the Committee made a finding of disgraceful, dishonourable or unprofessional conduct based on Dr. Pinto's failure to comply with a SCERP ordered by the ICRC. A reprimand and costs were ordered. This was an agreed statement of facts case and the Committee accepted the joint proposal on penalty.

In *CPSO v. Achiume*, 2015 ONCPSD 4, the Committee made a finding of disgraceful, dishonourable or unprofessional conduct based on Dr. Achiume's failure to comply with a SCERP in medical record keeping over a four year period. An aggravating factor in this case was that Dr. Achiume had previously appeared before the Discipline Committee on three occasions, on unrelated matters. The Committee's Order consisted of a suspension (minimum 1-month) until Dr. Achiume provided the College with proof of his compliance with the SCERP, a reprimand, and costs payable to the College. This was an agreed statement of facts case and the Committee accepted the joint proposal on penalty.

In *CPSO v. Rosenhek*, 2017 ONCPSD 51, the Committee found that Dr. Rosenhek engaged in disgraceful, dishonourable or unprofessional conduct by practising medicine without clinical supervision in breach of a 2010 Order of the Discipline Committee and contrary to the terms, conditions, and limitations on his certificate of registration. Dr. Rosenhek had a significant history with the College, including a number of cautions and a prior discipline finding. Dr. Rosenhek's cooperation and the agreement on penalty were mitigating factors, as was his decision to stop practising medicine during a period of time when he could not locate a

replacement supervisor. There were also many letters of support which the Committee considered as a mitigating factor. A one-month suspension, a reprimand, and costs payable to the College were ordered. Dr. Rosenhek had entered a plea of no contest and there was a Statement of Uncontested Facts. The Committee accepted the joint proposal on penalty.

In *CPSO v. Aziz*, S.B., 2014 ONCPSD 33, Dr. Aziz was found to have failed to maintain the standard of practice in his care of a woman with chest pain. He was also found to have engaged in disgraceful, dishonourable or unprofessional conduct for failing to cooperate with the College's investigation, and for breach of an interim undertaking with the College. The Committee ordered a three-month suspension, a reprimand, and the imposition of terms, conditions and limitations on his certificate of registration, including a period of supervision. Dr. Aziz was also required to pay costs to the College. This was an agreed statement of facts case and the Committee accepted the joint proposal on penalty.

On reviewing these cases, the Discipline Committee concluded that the proposed penalty was within the range of prior penalties of the Discipline Committee in similar cases.

Summary

The Committee accepted the parties' joint submission on penalty as an appropriate penalty in the circumstances of this case. The suspension and reprimand reflect the severity of the misconduct, and serve as specific deterrents to Dr. Taniguchi and general deterrents to the membership at large.

Dr. Taniguchi's undertaking made to the College prior to this hearing sets out in detail the length and nature of clinical supervision. Dr. Taniguchi must practice under the guidance of a clinical supervisor for six months. Dr. Taniguchi will review and make a written summary of the College policy *Professional Responsibilities in Post Graduate Medical Education;* and Dr. Taniguchi will complete a course in medical ethics. Six months after completion of clinical supervision, Dr. Taniguchi will undergo a practice reassessment.

This undertaking provides public assurance that in the future, Dr. Taniguchi will maintain the standard of practice.

ORDER

The Committee stated its finding in paragraph 1 of its written order of May 10, 2019. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Taniguchi attend before the panel to be reprimanded.

3. The Registrar suspend Dr. Taniguchi's certificate of registration for a period of two (2) months, commencing May 11, 2019 at 12:01 a.m.

4. Dr. Taniguchi pay costs to the College in the amount of $6,000.00 within thirty (30) days from the date of this Order.

At the conclusion of the hearing, Dr. Taniguchi waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

TEXT of PUBLIC REPRIMAND
Delivered May 10th, 2019
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. ALAN TANIGUCHI

Dr. Taniguchi,

It is profoundly disappointing to have you before the Discipline Committee particularly for such clearly unprofessional behaviour. There is no acceptable reason for you to have repeatedly ignored the orders from the College. Your lack of cooperation, at the very least, demonstrates a lack of respect for your governing body.

The College is charged with regulating the profession and relies on the honestly, integrity and full cooperation of its members to do so. Your behaviour was unacceptable. The public and the College expect more of physicians holding a Certificate of Registration.

The public invests great trust in the medical profession, and you must be worthy of that trust. An integral part of the public trust is that physicians will maintain the standard of practice and, if and when they fall short, they will promptly undertake remedial action, especially when instructed by ones governing body to do so. Your obstructive and delaying behaviour is of particular concern as in your academic practice, you are a role model for young doctors.

It is encouraging since November of 2018, that you have taken appropriate action and received highly positive reports from your supervisor. You have engaged in supportive counselling and the Committee encourages you to continue along this path. In the future, it will be important for you to understand your personal limitations and set realistic limits to your practice. The steps that you have taken lead us to believe you will do so.

You may sit down.