COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

IN THE MATTER OF:	The *Medical Act*, SNS 2011, c 38
BETWEEN:	
	The College of Physicians and Surgeons
	(the "College")
- and -	
	Dr. Michelle Ciach
	("Dr. Ciach")
DATE HEARD:	By written submissions dated July 5, 2023 and July 17, 2023, and by oral submissions on July 14, 2023.
LOCATION:	Halifax, Nova Scotia
HEARING COMMITTEE:	Nasha Nijhawan, Chair Gwen Haliburton Dr. Bakhtiar Kidwai Dr. Cathy MacDougall Dr. Michael Teehan
COUNSEL:	Jane O'Neill, KC for the College Amy MacGregor for Dr. Ciach
DECISION DATE:	August 4, 2023

DECISION

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1. Dr. Michelle Ciach and the College of Physicians and Surgeons of Nova Scotia (the "College") have reached a proposed settlement agreement (the "Settlement Agreement") in respect of two allegations of professional misconduct, which were referred to hearing by an Investigation Committee of the College. As required by s. 51 of the *Medical Act*, SNS 2011, c 38 (the "*Medical Act*") and s. 103 of the *Medical Practitioner Regulations* (the "*Regulations"*), the settlement agreement between the parties came before the Hearing Committee for review.

2. The Hearing Committee received submissions in writing from both parties on the settlement approval on July 5, 2023, and met to hear oral submissions on July 14, 2023. Following the hearing, the parties made further written submissions on July 17, 2023, in response to a request of the Hearing Committee. The Committee informed the parties on July 18, 2023, that it had decided to approve the proposed settlement agreement, with reasons to follow.

Background of allegation

3. Dr. Ciach is a family physician practicing in Halifax Regional Municipality. She has held a licence with the College since 2008. Her practice includes full scope primary care in family practice and long term care facility settings.

4. The parties have agreed to the factual basis for two distinct complaints against Dr. Ciach, which are set out in the Settlement Agreement. These are the facts on which the Hearing Committee has been asked to consider the proposed resolution of the complaint, and on which it relies. The background of the complaints is set out below by way of summary only.

5. The first complaint deals with signing a false statement on a death certificate. In the Settlement Agreement, Dr. Ciach acknowledges that on July 26, 2021, she signed a death certificate for a patient who had not died, completing the cause of death and leaving the date of death blank. Dr. Ciach intended to provide the death certificate to the daughter of the patient, who was returning to the United States and was concerned that her mother would pass away after she left the country.

The death certificate was not in fact provided to the daughter because of the intervention of Dr. Ciach's receptionist, who refused to release it once they discovered that the patient was still alive. The patient remained alive for more than a year after Dr. Ciach signed her death certificate.

6. The second complaint concerns Dr. Ciach's acknowledged repeated use of two colleagues' office signature stamps without their knowledge or consent to initiate prescriptions to herself and a family member, and her alteration of a prescription issued by another physician for a family member. Dr. Ciach was not truthful when confronted about these allegations by a colleague, and minimized her conduct.

7. Dr. Ciach has admitted that her actions amount to a breach of the College's *Professional Standard on Physician Obligations Regarding Certification of Death*, by signing a certificate of death and including a cause of death for a patient who had not died. Dr. Ciach has admitted that by initiating prescriptions for herself and a family member she contravened the College's *Professional Standards and Guidelines Regarding Treating Self and Family Members.* With respect to both complaints, Dr. Ciach had admitted to contravening the CMA *Code of Ethics and Professionalism* by falsely completing a death certificate, forging prescriptions, and not being truthful about the extent of her misconduct.

8. Dr. Ciach has admitted that she has accordingly engaged in professional misconduct as defined under the *Medical Act*.

Terms of the proposed settlement agreement

9. The Settlement Agreement includes the following sanctions:

    a. Dr. Ciach's certificate of registration shall be suspended for a period of six months, beginning on July 1, 2023 and ending on December 31, 2023.

    b. Dr. Ciach must complete the next available offering of the PROBE: Ethics and Boundaries Program at her own cost and obtain a grade of Unconditional Pass.

10. In addition, Dr. Ciach has agreed to pay $5,000 in costs to the College, in partial satisfaction of the College's cost of investigation.

Settlement approval by the Hearing Committee

11. The Investigation Committee has recommended that the Settlement Agreement be approved, being satisfied that the requirements of s. 102(1) of the *Regulations* have been met, namely that:

    a) The public is protected;

    b) The conduct or its causes can be, or have been, successfully remedied or treated, and the respondent is likely to successfully pursue any remediation or treatment required;

    c) The content of the proposed settlement agreement provides sufficient facts and admissions to support the agreed disposition; and

    d) The settlement is in the best interests of the public and the profession.

12. When considering whether to approve a proposed settlement agreement between the College and a member under s. 103 of the *Regulations*, the Hearing Committee will generally show deference to the recommendation of the parties and the Investigation Committee. As observed in *Re Rivas*:[1]

> In considering a proposed settlement agreement in this legislative context, the Hearing Committee is generally inclined to defer to the judgment of the Investigation Committee on the specific aspects of a settlement agreement. In most cases, the Investigation Committee will have engaged with the medical practitioner and the issues arising from a particular complaint in considerable detail over a number of meetings. They will have more knowledge of the circumstances than the Hearing Committee.
>
> Settlement Agreements are negotiated between the Registrar and the practitioner and will include reasonable compromises acceptable to the Investigation Committee. Resolving complaints reasonably without a formal

[1] 2019 CanLII 92722 (NS CPS) at para 19-20.

hearing benefits both the College and the practitioner. If recommendations from the Investigation Committee fall within a reasonable range of dispositions, the Hearing Committee will accept a settlement agreement that is recommended.

13. In the instant case the Hearing Committee is cognizant that the Settlement Agreement itself notes that the parties were not able to reach agreement based on any form of penalty other than a suspension from practice of this length.

Protection of the public

14. In considering whether to accept the recommended Settlement Agreement, the Committee must consider the primary purpose of professional discipline under the *Medical Act*, which is the protection of the public.

15. Section 5 of the *Medical Act* provides for the purposes and duties of the College:

> 5 In order to
>
> (a) serve and protect the public interest in the practice of medicine; and
>
> (b) subject to clause (a), preserve the integrity of the medical profession and maintain the confidence of the public and the profession in the ability of the College to regulate the practice of medicine, the College shall
>
> (c) regulate the practice of medicine and govern its members through
>
> (i) the registration, licensing, professional conduct and other processes set out in this Act and the regulations,
> (ii) the approval and promotion of a code of ethics
> (iii) the establishment and promotion of standards for the practice of medicine, and
> (iv) the establishment and promotion of a continuing professional development program; and
>
> (d) do such other lawful acts and things as are incidental to the attainment of the purpose and objects of the College.

16. Counsel for Dr. Ciach has submitted that there are no features of this case which suggest that Dr. Ciach will reoffend. The Committee defers to the recommendation of the Investigation Committee, and to the agreement between the parties, who have more knowledge of the circumstances that would give rise to any ongoing concern about public protection.

Is the proposed penalty fair, reasonable and appropriate?

17. For the reasons that follow, the Hearing Committee is satisfied that despite the impact of the suspension on Dr. Ciach's patient population, it is a fair, reasonable and appropriate penalty in all of the circumstances, which achieves the objective of s. 5 of the *Medical Act*.

18. The Committee is expected to consider the following factors when determining whether a proposed penalty is fit, or falls within a reasonable range of dispositions:[2]

    a. Proportionality, by consideration of the nature of the misconduct and any aggravating or mitigating circumstances;

    b. The objectives of sanctions in professional discipline:[3]

        i. Denunciation of the misconduct;

        ii. Specific deterrence of the member from engaging in further misconduct;

        iii. General deterrence to other members from engaging in like misconduct;

        iv. Rehabilitation or remediation of the member; and

[2] *Matheson v. College of Physicians and Surgeons*, 2010 PECA 5 at para 150-151; *CPSO v. Nadon*, 2020 ONCPSD 32 at para 23; *Hosein (Re)*, 2020 CanLII 31686 (NSCPS) at para 12, citing *CPSO v. Dr. Javad Peirovy*, 2018 ONCA 420 at para 63-65.
[3] *Re Richardson, 2022 CanLII 10* (NSCPS*),* para 45-49.

c. Fairness when compared with penalties imposed in similar cases.

(a) Nature of the misconduct, aggravating or mitigating factors

19. The detailed facts of Dr. Ciach's misconduct are set out in the Settlement Agreement, and summarized above.

20. The nature of the misconduct is very serious, in that it involves a significant breach of public trust in a physician's role in creating a permanent legal record of death, and of trust among members of the profession in the forging or alteration of prescriptions using another physician's name. The two complaints can be fairly characterized as raising issues of honesty and integrity fundamental to the practice of medicine.

21. The Hearing Committee also acknowledges that despite the seriousness of the misconduct, there are no issues of patient care or safety raised by the complaints.

22. The Committee considered that the following mitigating factors to justify the penalty in light of the seriousness of the misconduct:

a. Dr. Ciach has no prior disciplinary history with the College;

b. Dr. Ciach has expressed remorse for her actions and acknowledged her wrongdoing;

c. Dr. Ciach has cooperated with the College in its investigation;

d. There is no suggestion that any involved prescription was medically unnecessary or that they were improperly used by Dr. Ciach or her family member. None of the prescriptions were for narcotics;

e. Dr. Ciach was experiencing a period of particular personal and professional stress during the time when the misconduct arose.

23. The Committee considered that the following aggravating factors justify the length of the period of suspension:

a. The allegations involve multiple and repeated incidences of dishonesty or breach of trust, in different circumstances and for different reasons, and not an isolated incident of a lapse in judgment.

(b) Objectives of discipline

24. The Committee is satisfied that the suspension of Dr. Ciach's license, and order of adverse costs, serve the purpose of denunciation and both specific and general deterrence. The boundaries course required by the College serves the purpose of rehabilitation of the member, with a view to the protection of the public.

(c) Parity

25. The parties have provided a number of cases demonstrating comparable penalties in similar cases, in order to assist the Hearing Committee to determine whether the Settlement Agreement falls within a range of reasonable dispositions. The Hearing Committee notes that this case deals with two separate complaints, and the proposed penalty is intended to account globally for both.

26. With respect to the misconduct relating to the false execution of a death certificate, the parties were not able to supply the Hearing Committee with any cases with closely similar facts. However, the Hearing Committee considered the following cases, which satisfy it that a moderate period of suspension is an appropriate penalty in this case.

27. In *GZ v JLD, MD,* the Ontario Health Professions Appeal and Review Board considered the reasonableness of the decision of the Investigation Committee of the College of Physicians and Surgeons of Ontario to take no action after considering a broad complaint of negligence in relation to palliative care of the complainant's mother. Among other allegations, the complainant alleged that the fact that the death certificate had been pre-filled with a cause of death and signed prior to the death (with the date of death blank) before a hospital transfer took place indicated that the physician had "left the patient to die".[4]

[4] 2016 CanLII 75862 (ON HPARB) ("*JLD*").

28. The Investigation Committee of the College in that case declined to pursue discipline, finding no concerns with the physician's overall care of the patient. It noted that it was "common practice among palliative care physicians" to partially complete a death certificate to ensure accuracy and to be finalized upon death by the attendant. In *JLD*, a separate certificate was in fact completed after a death in hospital. Based on this factual background, the Board in *JLD* found the Investigation Committee's decision reasonable, but recommended that the College "make members aware that they should only sign a certificate of death after a patient has died".[5]

29. The Hearing Committee has no evidence in this case about whether pre-filling or pre-signing a death certificate is a common practice for Dr. Ciach or for other long term care or palliative care physicians in Nova Scotia. Overall, it considers the *JLD* case to be less serious than Dr. Ciach's case in context, where death of the patient was not imminent, and the false certificate was intended to be provided directly to a family member who could have used it for many improper purposes.

30. At the opposite end of the spectrum, in *Galipeau v CPSO*, a physician pleaded guilty to professional misconduct for orchestrating a cover up of the death of a patient in a nursing home that he owned and where he was the medical director, including lying to police, requiring his staff to lie to police, the coroner, family members of the patient and others, and falsifying the cause of death on a medical certificate of death.[6] The case resulted in criminal charges against the physician to which he pled guilty, a coroner's inquest and civil litigation by the family of the patient. The physician was permitted to practice for 24 months in an underserviced area to avoid a 12-month suspension from practice, considered to be an appropriate penalty in that case. *Galipeau* is a far more serious case than the one before this Committee.

[5] *JLD*, supra at para 38.
[6] 1999 ONCPSD 21.

31. A number of other cases provided by the parties involved the completion of receipts without particulars by other regulated health professionals in Ontario (not physicians). These cases resulted in periods of suspension of one month,[7] four months,[8] or six months,[9] depending on the circumstances. The Hearing Committee considers that while there is a similarity in the nature of the concern, this type of misconduct is much less serious than the admitted facts of this case relating to the death certificate.

32. A medical certificate of death is a permanent legal record, and a physician who completes one certifies by their signature that the named person died on the date and from the causes stated on the form. To sign a death certificate prior to the death of a person is to knowingly sign a false statement on an official government record which cannot be compared with signing blank receipts.

33. The parties provided the Hearing Committee with a number of cases dealing with self-prescribing or prescribing to family members, where the range of penalties also involved short or moderate suspensions from practice.

34. The most comparable case available is *Raddatz v CPSO*, in which the physician also used a colleague's prescription pad to self-prescribe, and wrote dozens of prescriptions for four family members over a period of two years.[10] With only one exception, the prescriptions were not for any controlled substances or narcotics. In *Raddatz*, the physician admitted the misconduct and the parties made a joint recommendation for a six-month suspension and completion of the PROBE training program, which was accepted by the Discipline Committee. Though more significant in frequency and duration, the essential character of the misconduct by Dr. Raddatz is the same as in the instant case.

[7] *College of Massage Therapists of Ontario v. Shiwen Zhu*, 2017 ONCMTO 2.
[8] *College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario v. Sun*, 2022 ONCTCMPAO 19.
[9] *College of Massage Therapists v. Wei Lei*, 2016 ONCMTO 8.
[10] 2020 ONCPSD 27.

35. In considering the principle of parity, and acknowledging that the College seeks to impose a single penalty for two separate complaints of misconduct, either of which could itself have resulted in a suspension from practice, the Hearing Committee agrees that an overall six-month suspension is a fair and reasonable penalty for Dr. Ciach.

36. It is appropriate for the College to be concerned about the impact of disciplinary sanctions on the timely access of primary care to patients, as part of its obligation to serve and protect the public interest in the practice of medicine. However, the purpose and duty of the College is not to ensure access to primary care, which is the legislated responsibility of the Minister of Health,[11] but to preserve the integrity of the medical profession and the public's confidence in its regulation.

Timing of the suspension

37. The parties agreed that Dr. Ciach would commence her six-month suspension from practice on July 1, 2023, before it was submitted for approval by the Hearing Committee. During the oral hearing on July 14, 2023, the Committee asked the parties whether there was any reason for this timing and none was supplied by either party.

38. Allowing a physician to start a suspension before it is approved by the Hearing Committee poses two challenges.

39. First, there is no guarantee that the Hearing Committee will approve the settlement agreement without modification, or that any proposed modifications by the Hearing Committee will be acceptable to the parties. The matter could therefore still be referred to a hearing, and the proposed penalty vacated. The approval of a Hearing Committee is required, and implementation of a settlement prior to approval disregards the Committee's role.

[11] *Health Authorities Act*, 2014, c 32, s. 6.

40. Second, where the implementation of a penalty has an impact on public provision of medical services – such as the temporary closure of a practice – the public does not have the benefit of the reasons of the Hearing Committee to understand the underlying admitted facts or the College's position on the discipline. This undermines the statutory duty of the College to maintain public confidence in the professional regulation of physicians. The Committee understands that, in this case, the closure of Dr. Ciach's practice prior to the settlement approval hearing resulted in a lack of clarity for her patients which the College was unable to respond to directly.

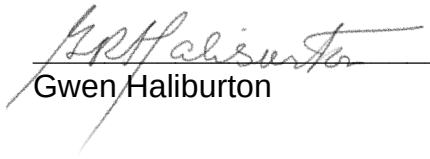
41. The Committee wishes to express its disapproval of the practice of implementing settlement terms prior to settlement approval, though it will not withhold approval of the retroactive start date for Dr. Ciach's suspension in this case.

Conclusion and Order

42. For the reasons set out above, the Committee accepts the recommendation of the Investigation Committee and the parties.

43. The Committee approves the Settlement Agreement in the form appended to this decision as Appendix "A".

Nasha Nijhawan, Chair



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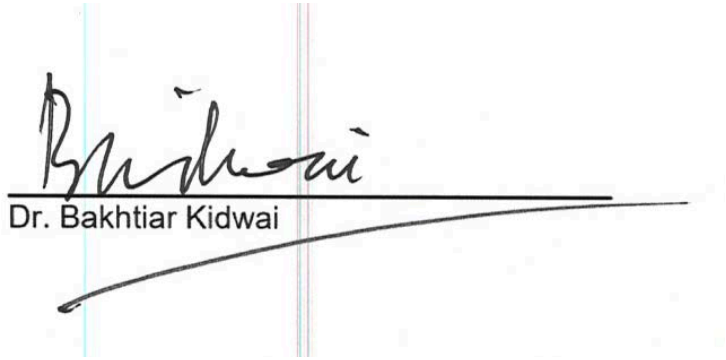

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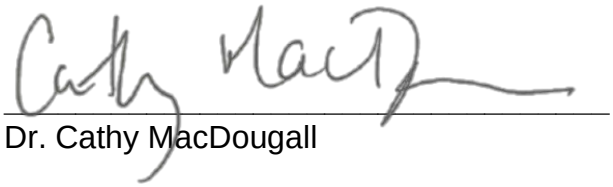

Dr. Cathy MacDougall

Dr. Michael Teehan

Appendix "A"

PROVINCE OF NOVA SCOTIA)
CITY OF HALIFAX)

IN THE MATTER OF: **The College of Physicians and Surgeons of Nova Scotia**

- and –

IN THE MATTER OF: **Dr. Michelle Ciach**

SETTLEMENT AGREEMENT

Dr. Michelle Ciach, a medical practitioner in the Province of Nova Scotia, and a member of the College of Physicians and Surgeons of Nova Scotia (the "College"), hereby agrees with, and consents to, the following in accordance with the provisions of the *Medical Act,* SNS 2011, c 38:

AGREED FACTS

1. This Settlement Agreement arises from two separate complaints, one initiated on August 6, 2021 and one initiated on October 28, 2021.

2. With respect to first complaint, on July 26, 2021, Dr. Ciach signed a death certificate for a patient who had not, in fact, died. Dr. Ciach, completed the cause of death and left the date of death blank. At the time of the Committee's referral to hearing more than a year later, the patient remained alive.

3. Dr. Ciach left the completed death certificate along with an Expected Death at Home form on her receptionist's desk for the patient's daughter to pick up the following day.

4. When the patient's daughter presented to pick up the documents, the receptionist noted to the daughter that no date of death was included in the death certificate. The daughter explained that her mother was still alive. The daughter noted she was returning to the United States and she was concerned that her mother would pass away after she left.

5. The receptionist did not give the patient's daughter the death certificate.

6. Dr. Ciach stated that providing a death certificate prior to someone dying in a nursing home makes it easier for the families and for staff as it ensures there is no delay if the doctor cannot attend on short notice.

7. Dr. Ciach acknowledges that signing a death certificate before a patient has died is not appropriate and she will not continue the practice.

8. A completed Medical Certificate of Death is a permanent legal record of the death of an individual. It records the personal information of the deceased and the details of death that are legally required to issue a burial permit, to settle the estate, insurance and pensions and to comply with the Nova Scotia *Vital Statistics Act*. A completed Medical Certificate of Death is required before funeral arrangements can be finalized and before funeral directors can prepare the remains of the deceased.

9. The College's *Professional Standard on Physician Obligations Regarding Certification of Death* provides that it should be completed no more than twenty-four hours *after* death.

10. To avoid needless delays and stress for friends and families of the deceased, physicians have a professional obligation to act in good faith and a legislated responsibility to be available (or to make arrangements with an alternate physician or nurse practitioner for an expected death) to complete a Medical Certificate of Death. Dr. Ciach admits she made no attempts in this regard but did not feel she had any colleagues that she could ask to assist her.

11. Physicians are expected to stay current with and abide by these standards and guidelines.

12. With respect to the second complaint, Dr. Ciach initiated prescriptions for herself and a family member and attributed those to two other physicians by using their office signature stamps, without their knowledge or consent.

13. Dr. Ciach initiated these false prescriptions on several occasions over several months.

14. Dr. Ciach also altered a prescription issued by another physician for one of her family members without that physician's knowledge or consent.

15. When confronted, Dr. Ciach only admitted to using another physician's prescription stamp for an antibiotic for a family member once.

16. The *College's Professional Standards and Guidelines Regarding Treating Self and Family Members* require that physicians refrain from treating themselves, family members or anyone with whom a physician has close personal or emotional involvement. There are limited circumstances where the risks associated with treatment are outweighed by the benefits of providing the treatment. These two instances include providing infrequent treatment for minor conditions when there is no one else available and in emergency situations where there is no one else available or qualified to do so. This was not the case.

17. The Canadian Medical Association *Code of Ethics and Professionalism* articulates the ethical and professional commitments and responsibilities of the medical profession. The Code provides standards of ethical practice to guide physicians in fulfilling their obligation to provide the highest standard of care and to foster patient and public trust in physicians and the profession.

18. Trust is central to providing the highest standard of care to the ethical practice of medicine. An honest physician is forthright, respects the truth, and does their best to seek, preserve and communicate that truth sensitively and respectfully. A physician who acts with integrity demonstrates consistency in their intentions and actions and acts in a truthful manner in accordance with professional expectations, even in the face of adversity.

19. Dr. Ciach practises family medicine, many of her patients are elderly and she provides full scope primary care as well as care to patients living in long term care facilities. She is also the Medical Director and founder of the Clayton Park Community Wound Care Clinic.

ALLEGATIONS OF MISCONDUCT

20. The Investigation Committee referred both complaints to a Hearing Committee.

21. With respect to the first complaint, Dr. Ciach contravened the College's *Professional Standard on Physician Obligations Regarding Certification of Death* which states it should be completed no more than 24 hours *after* the death has occurred. Dr. Ciach created a false record when she signed a death certificate and included a cause of death when, in fact, the patient had not died.

22. With respect to the second complaint, Dr. Ciach contravened the College's *Professional Standards and Guidelines Regarding Treating Self and Family Members* by initiating prescriptions for herself and a family member.

23. With respect to both complaints, Dr. Ciach contravened the CMA *Code of Ethics and Professionalism* by forging prescriptions, not being truthful about the extent of the misconduct and by falsely completing a death certificate.

24. Dr. Ciach engaged in professional misconduct which is defined under the *Medical Act* as:

> "professional misconduct" includes such conduct or acts in the practice of medicine that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional and that, without limiting the generality of the foregoing, may include breaches of
>
> (i) the Code of Ethics approved by the Council,
>
> (ii) the accepted standards of the practice of medicine, and
>
> (iii) this Act, the regulations and policies approved by the Council;

ADMISSIONS

25. Dr. Ciach admits all of the facts and statements set out in paragraphs 1-24.

26. Dr. Ciach admits that she contravened the *Professional Standard on Physician Obligations Regarding Certification of Death*.

27. Dr. Ciach admits that she contravened the *Professional Standards and Guidelines Regarding Treating Self and Family Members*.

28. Dr. Ciach admits that she contravened the Canadian Medical Association *Code of Ethics and Professionalism*.

29. Dr. Ciach admits that she engaged in professional misconduct as defined in the *Medical Act*.

DISPOSITION

30. Dr. Ciach accepts a six-month suspension of her license to practice medicine.

31. The Investigation Committee considered the impact of a suspension on timely access to care to patients. The Committee offered forms of penalty other than a suspension but the parties were unable to reach an agreement.

32. Dr. Ciach's suspension will begin on July 1, 2023 at 12:01 a.m. and end on December 31, 2023 at 11:59 p.m.

33. Dr. Ciach is required to complete the next available offering of the PROBE: Ethics and Boundaries Program at her cost and obtain a grade of Unconditional Pass. If this grade is not obtained on the first attempt, the course will be repeated at the next offering until a grade of Unconditional Pass is achieved.

RETENTION OF JURISDICTION

34. The Hearing Committee of the College, in its present or successor form, retains jurisdiction over this matter to deal with any issues of interpretation, implementation, or variation of this agreement.

COSTS

35. Dr. Ciach agrees to pay costs to the College in the amount of $5000.00 inclusive of HST, representing a portion of the College's costs of investigating this matter. These costs shall be payable by Dr. Ciach in monthly instalments of $500.00 commencing on the first day of the month following the acceptance of the Settlement Agreement by the Hearing Committee.

PUBLICATION

36. This Settlement Agreement and any decision rendered by a Hearing Committee approving it, shall, subject to the Publication Ban, be published on the College's website.

EFFECTIVE DATE

37. This Settlement Agreement shall only become effective and binding when it has been recommended for acceptance by an Investigation Committee of the College, and accepted by the Hearing Committee appointed to hear this matter.

A. Bradley
Witness

Dr. Michelle Ciach

Dated June 29, 2023

Witness

Jane O'Neill, KC
Counsel for the College of Physicians and Surgeons of Nova Scotia

Dated Aug 4, 2023

Witness

Chair
Investigation Committee, College of Physicians and Surgeons of Nova Scotia

Dated June 29, 2023

Witness

Chair
The Hearing Committee, College of
Physicians and Surgeons of Nova Scotia

Dated August 4th, 2023