24-0310

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 ("*Code"*) respecting one **DR. KEVIN KLIMAN,** of the City of Toronto, in the Province of Ontario;

AND IN THE MATTER OF the *Dentistry Act* and Ontario Regulation 853, Regulations of Ontario, 1993, as amended ("Dentistry Act Regulation").

AND IN THE MATTER OF the *Statutory Powers Procedure Act*, Revised Statutes of Ontario, 1990, Chapter S.22, as amended; 1993.

To: Dr. Kevin Kliman
325 Front St W, 4th floor
Toronto M5V 2Y1

NOTICE OF HEARING

TAKE NOTICE THAT IT IS ALLEGED THAT:

1. You committed an act or acts of professional misconduct as provided by section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2019-2020, you contravened section 2(1) of the Ontario Regulation 853, Regulations of Ontario, 1993, in that you contravened a standard of practice or failed to maintain the standards of practice of the profession.

   Particulars:

   - In or about 2019-2020, you provided orthodontic treatment to LS (the Patient).
   - You misdiagnosed the Patient with a Class I occlusion when they likely had a

Class II malocclusion at the molars, Class II right cuspid and Class III left cuspid malocclusion.

- Your diagnosis of the Patient was incomplete and did not include relevant complicating factors, including but not limited to Patient's missing premolars, minimal overbite, crossbites, and midline discrepancy.
- Your case work-up was incomplete because you did not perform any orthodontic analysis or take any necessary diagnostic radiographs and did not create or provide the Patient with a treatment plan for their orthodontic treatment.
- You did not adequately monitor the Patient's orthodontic progress during the treatment to assess whether detrimental changes were occurring.
- You did not follow up with the Patient when they did not "check-in" after 90 or 180 days of treatment.
- You provided treatment that worsened the Patient's bite and resulted in an edge-to-edge bite and parafunction.
- You proceeded with refinements of the Patient's treatment even though the Patient did not complete their "check-in" and wanted you to correspond with their treating dentist. You requested radiographs from the Patient's treating dentist but proceeded with refinement treatment without receiving the radiographs.
- You proposed a refinement treatment plan that you knew or ought to have known would result in an open bite.
- You did not discuss the risks, benefits, side effects, and alternatives of the orthodontic treatment with the Patient before beginning the treatment.
- You did not discuss with the Patient the specific risks that the treatment would result in an open or edge-to-edge bite and parafunction and the impact that this outcome would have on the Patient. You did not explain to the Patient what an open bite is.
- You did not recommend that the Patient consult an orthodontist to discuss alternative treatment options, including more advanced orthodontic treatment options.
- The Patient was required to sign an informed consent form at the same appointment when scans were taken and before the Patient had an opportunity to review the images depicting the projected treatment outcome.
- You did not discuss any treatment plan with the Patient.

- You delegated your responsibility to obtain the Patient's informed consent to treatment to administrative staff and never communicated with the Patient directly about their informed consent to the treatment.
- You did not communicate directly with the Patient about their treatment progress, even when the Patient asked to speak to someone about the fit of their aligners and have their treatment reviewed by a human.
- You did not respond substantively to the Patient's treating dentist when they raised concerns about the Patient's bite and the orthodontic treatment plan.

2. You committed an act or acts of professional misconduct as provided by section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2019-2020, you contravened section 2(5) of the Ontario Regulation 853, Regulations of Ontario, 1993, in that you treated or attempted to treat a disease, disorder or dysfunction of the oral-facial complex that you knew or ought to have known was beyond your expertise or competence.

   Particulars:

   - You knew or ought to have known that the Patient's case was complex and was not suitable for the type of clear aligner therapy that you provided.
   - You did not refer the Patient to an orthodontist for consultation and/or treatment.
   - You did not understand the potential effects of your treatment on the Patient's occlusion.
   - You thought that the tooth movement in this case was "minor" when it had a significant detrimental impact on the Patient.
   - You thought that an open bite was beneficial to the Patient.

3. You committed an act or acts of professional misconduct as provided by section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2019-2020, you contravened section 2(7) of the Ontario Regulation 853, Regulations of Ontario, 1993, in that you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other health-related purpose in which a consent is required by law, without such a consent.

Particulars:

- You did not discuss the risks, benefits, side effects, and alternatives of the orthodontic treatment with the Patient before beginning the treatment.
- You did not discuss with the Patient the specific risks that the treatment would result in an open or edge-to-edge bite and parafunction and the impact that this outcome would have on the Patient. You did not explain to the Patient what an open bite is.
- You did not recommend that the Patient consult an orthodontist to discuss alternative treatment options, including more advanced orthodontic treatment options.
- The Patient was required to sign an informed consent form at the same appointment when scans were taken and before the Patient had an opportunity to review the images depicting the projected treatment outcome.
- You did not discuss any treatment plan with the Patient.
- You delegated your responsibility to obtain the Patient's informed consent to treatment to administrative staff and never communicated with the Patient directly about their informed consent to the treatment.

4. You committed an act or acts of professional misconduct as provided by section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2019-2020, you contravened section 2(25) of the Ontario Regulation 853, Regulations of Ontario, 1993, in that you failed to keep records as required by the regulations.

   Particulars:

   - Your records for the Patient were incomplete, and did not include:
     - Side views showing the Patient's bite, or adequate smile view photographs;
     - Diagnostic radiographs;
     - An orthodontic analysis;
     - A problem list;
     - An objective list; or
     - A treatment plan.

Such further and other particulars will be provided from time to time, as they become known.

AND TAKE NOTICE THAT the said allegations respecting professional misconduct will be heard and determined by a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario ("panel") on a date and time to be agreed upon by the parties, or on a date to be fixed by the Chair of the Discipline Committee, at the offices of the Royal College of Dental Surgeons of Ontario, 6 Crescent Road, Toronto, Ontario, M4W 1T1, or by electronic hearing as required. You are required to appear in person or by a legal representative before the panel with your witnesses, if any, at the time and place aforesaid.

ONCE A DATE IS FIXED, IF YOU DO NOT ATTEND ON THE FIXED HEARING DATE, THE PANEL MAY PROCEED IN YOUR ABSENCE AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE OF THE PROCEEDINGS.

The *Code* provides that if a panel finds that you have committed an act of professional misconduct, it may make an order doing any one or more of the following:

(1) directing the Registrar to revoke your certificate of registration;
(2) directing the Registrar to suspend your certificate of registration for a specified period of time;
(3) directing the Registrar to impose specified terms, conditions and limitations on your certificate of registration for a specified or indefinite period of time;
(4) requiring you to appear before the panel to be reprimanded;
(5) requiring you to pay a fine of not more than $35,000.00 to the Minister of Finance;

or any combination thereof.

Furthermore, the *Code* provides that if a panel is of the opinion that the commencement of these proceedings is unwarranted, it may make an order requiring the College to pay all or part of your legal costs.

The *Code* also provides that in an appropriate case, a panel may make an order requiring you, in the event the panel finds you have committed an act or acts of professional misconduct or finds you to be incompetent, to pay all or part of the following costs and expenses:

1. the College's legal costs and expenses;

2. the College's costs and expenses incurred in investigating the matter; and
3. the College's costs and expenses incurred in conducting the hearing.

If you have not done so already, you are entitled to and are well advised to retain legal representation to assist you in this matter.

You are entitled to disclosure of the evidence in this matter in accordance with section 42(1) of the *Code*. You or your representative may contact the prosecutor for the College, [redacted], in this matter at:

[redacted]

You, or your legal representative, should familiarize yourself with your disclosure obligations under law, including section 42.1 of the *Code*.

DATED at Toronto, this 24th day of April, 2024.

Royal College of Dental Surgeons of Ontario

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act*, *1991*, Statutes of Ontario, 1991, Chapter 18 (*"Code"*) respecting one **DR. KEVIN KLIMAN,** of the City of Toronto, in the Province of Ontario;

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AND IN THE MATTER OF the *Statutory Powers Procedure Act*, Revised Statutes of Ontario, 1990, Chapter S.22, as amended.

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