DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

Citation: Royal College of Dental Surgeons of Ontario v. Kliman, 2026 ONRCDSO 5

Date: 2026-04-14

File Nos.: 24-0310, 24-0311, 24-0312, 24-0313, 24-0314, 25-0440, 25-0441

BETWEEN:

Royal College of Dental Surgeons of Ontario

-and-

Dr. Kevin Kliman
Registration No. 74247

FINDING AND PENALTY REASONS

RESTRICTION ON PUBLICATION

In the matter of the Royal College of Dental Surgeons of Ontario and Dr. Kliman the Discipline Panel ordered, under ss 45(3) of the Health Professions Procedural Code, that no person shall publish or broadcast the identity of any patients of the Registrant, or any information that could disclose the identity of any patients who are named in the Notice of Hearing and/or the Agreed Statement of Facts in this matter.

PANEL MEMBERS:
Judy Welikovitch, Public Member (Chair)
Osama Soliman, Professional Member
Andrea Gonsalves, Subject Matter Expert

APPEARANCES:
Ahmad Mozaffari, for the College
Geoffrey Mowatt, for Dr. Kliman

Heard: February 4, 2026, by video conference

REASONS FOR DECISION

[1] This matter came on for a hearing before a Panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario (the "College") on February 4, 2026. The hearing was held by way of videoconference.

[2] This matter involves seven (7) Notices of Hearing issued in 2024 and 2025 containing allegations of professional misconduct by Dr. Kevin Kliman in respect of clear aligner therapy treatments he provided to seven patients through an online platform operated by a third party, namely Smile Direct Canada ("**SDC**").

[3] Each of the Notices of Hearing was entered as an exhibit, as follows:

(a) Matter No. 24-0310, Exhibit 1;
(b) Matter No. 24-0311, Exhibit 2;
(c) Matter No. 24-0312, Exhibit 3;
(d) Matter No. 24-0313, Exhibit 4;
(e) Matter No. 24-0314, Exhibit 5;
(f) Matter No. 25-0440, Exhibit 6; and
(g) Matter No. 25-0441, Exhibit 7.

THE ALLEGATIONS

[4] In each of the seven (7) Notices of Hearing, the College alleged that Dr. Kliman committed an act or acts of professional misconduct as provided by s. 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, SO 1991, c 18, (the "**Code**"):

(a) In that he contravened a standard of practice or failed to maintain the standards of practice of the profession relative to his patients LS (File No 24-0310), JM (File No. 24-0311), SC (File No. 24-0312), GG (File No. 24-0313), DA (File No. 24-0314), DH (File No. 25-0440) and IO (File No. 25-0441), contrary to section 2(1) of Ontario Regulation 853, Regulations of Ontario, 1993 (the "**Professional Misconduct Regulation**");

(b) In that he treated or attempted to treat a disease, disorder or dysfunction of the oral-facial complex that he knew or ought to have known was beyond his expertise or competence, contrary to section 2(5) of the Professional Misconduct Regulation;

(c) In that he treated his patients for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in which a consent is required by law, without such consent, contrary to section 2(7) of the Professional Misconduct Regulation; and

(d) In that he failed to keep records as required by the Regulations, contrary to section 2(25) of the Professional Misconduct Regulation.

[5] The particulars with respect to each of the seven (7) patients was set out in the Notices of Hearing, which are appended to these reasons. They were also set out in detail in a global Agreed Statement of Facts and Admission of Professional Misconduct (the "**ASF**"), which was signed by Dr. Kliman on 30 January 2026 and entered as Exhibit 9 (reproduced below; Tabs not included).

[6] In response to a question posed by the Panel about the third allegation concerning the requirement to obtain patient consent where "required by law" in advance of providing treatment, College counsel clarified that the legal requirement is contained in s. 10 of the *Health Care Consent Act, 1996*, SO 1996, c 2, Schedule A.

[7] Further in response to a question posed by the Panel about the fourth allegation concerning the Registrant's failure to keep records "as required", College counsel clarified that the relevant recordkeeping requirement is contained in section 38 of Ontario *Regulation 547/93* made pursuant to the *Drug and Pharmacies Regulation Act*, RSO 1990, c H.4.

THE REGISTRANT'S PLEA

[8] The Registrant admitted to each of the allegations in each of the seven (7) Notices of Hearing. The Chair conducted an oral plea inquiry to confirm that the Registrant's admissions of professional misconduct were voluntary, informed and unequivocal. The ASF entered into evidence and signed by the parties also confirms Dr. Kliman's understanding of the nature of the allegations and the consequences of admitting to the alleged acts of professional misconduct, and that he voluntarily decided to admit the allegations against him.

[9] The Panel was satisfied that Dr. Kliman's plea was voluntary, informed and unequivocal.

THE EVIDENCE

[10] As noted, the parties provided the Panel with an ASF (Exhibit 9). The relevant facts set out in the ASF are as follows:

"Background

1. At the material times, Dr. Kevin Kliman (the "**Registrant**"), was a duly registered member of the College practising at 325 Front Street West, in Toronto, Ontario (the "**Clinic**"). A copy of the Registrant's profile from the Dentist Register is attached hereto as "**Tab A**".

2. Between 2018 and 2024, the Registrant offered clear aligner therapy treatment to patients. The Registrant provided that treatment utilizing an online platform operated by a third party, Smile Direct Canada ("**SDC**").

3. It is agreed that the Registrant provided treatment to Patients 1-7 through the platform operated by SDC.

NOTICE OF HEARING 24-0310

Patient 1 – LS

4. In May, 2019, Patient 1 sought orthodontic treatment from the Registrant, through the SDC platform. Patient 1 received treatment from the Registrant from 2019 until 2020.

5. Over the course of Patient 1's treatment, and despite being the dentist responsible for their treatment, the Registrant never met or communicated directly with Patient 1.

Failure to obtain informed consent

6. The Registrant failed to obtain informed consent to treatment prior to commencing treatment. SDC only obtained an executed generic "informed consent" form. The Registrant delegated his responsibility to obtain Patient 1's consent to treatment to administrative staff and never communicated with Patient 1 directly to obtain their informed consent to the treatment, or about their treatment more broadly, and to allow for an opportunity to ask questions.

7. Patient 1 was required to sign a generic consent form at the same appointment when scans were taken and before Patient 1 had an opportunity to review images depicting the projected treatment outcome.

8. The Registrant did not discuss a treatment plan with Patient 1, nor did he discuss the risks, benefits, side effects, and alternatives of the orthodontic treatment with Patient 1 before beginning the treatment. In particular, the Registrant did not discuss with Patient 1 the specific risks that the treatment could result in an open or edge-to-edge bite and parafunction, and the impact that this outcome would have on Patient 1. The Registrant did not explain to Patient 1 what an open bite is.

9. The Registrant himself did not recommend that Patient 1 consult an orthodontist to discuss alternative treatment options, including more advanced orthodontic treatment options.

10. It is agreed that the failure to obtain informed consent through a personal interaction with Patient 1 also constitutes a failure to maintain the standards of practice of the profession.

Failure to Maintain the Standards of Practice of the Profession

11. In addition to the conduct described in paragraphs 5-9 above, it is agreed that in his treatment of Patient 1, the Registrant further failed to maintain the standards of practice in the following ways:

    a. the Registrant failed to properly diagnose Patient 1, and his diagnosis was incomplete as it did not include relevant complicating factors, including the fact that Patient 1 had missing premolars, had a minimal overbite and crossbites, and midline discrepancies;
    b. the Registrant diagnosed Patient 1 with a Class I occlusion when Patient 1 likely had a Class II malocclusion at the molars, Class II right cuspid and Class III left cuspid malocclusion;
    c. the Registrant's case work-up regarding Patient 1 was incomplete. The Registrant did not perform a sufficient orthodontic analysis or take any diagnostic radiographs of Patient 1. The Registrant did not create or provide to Patient 1 a sufficient or appropriate treatment plan for their orthodontic treatment;
    d. the Registrant did not adequately monitor Patient 1's orthodontic progress during their treatment to assess whether detrimental changes were occurring. In addition, when Patient 1 did not attend "check-in" appointments after 90 and 180 days of treatment, the Registrant did not follow up personally with Patient 1;
    e. the Registrant provided treatment that worsened Patient 1's bite and resulted in an edge-to-edge bite and parafunction;
    f. when Patient 1 requested refinements to their aligners, the Registrant did not schedule a follow-up appointment to discuss their concerns. Rather, the Registrant proposed a refinement treatment plan that he ought to have known would result in an open bite;
    g. the Registrant proceeded with refinements of Patient 1's treatment even though Patient 1 did not attend her "check-in" appointment and Patient 1 had requested

that the Registrant speak with their treating dentist, which the Registrant did not do. Although the Registrant requested radiographs from Patient 1's treating dentist, the Registrant proceeded with refinement treatment without receiving the radiographs;

h. the Registrant did not communicate directly with Patient 1 about their treatment progress, even when Patient 1 asked to speak to someone about the fit of their aligners and to have their treatment reviewed by a dentist; and
i. the Registrant did not respond substantively to Patient 1's treating dentist when their treating dentist raised concerns about Patient 1's bite and the orthodontic treatment plan.

The Registrant provided treatment that was beyond his expertise or competence

12. The Registrant ought to have known that Patient 1's case was complex and was not suitable for the type of clear aligner therapy that the Registrant provided.

13. The Registrant did not refer Patient 1 to an orthodontist for consultation and treatment.

14. The Registrant did not understand the potential effects of his treatment on Patient 1's occlusion. The Registrant thought that the tooth movement in this case was "minor" when in fact it had a significant detrimental impact on Patient 1’s bite. In addition, the Registrant thought that an open bite was beneficial to Patient 1.

Failure to Keep Records as Required

15. The Registrant’s records for Patient 1 were incomplete, and did not include:

    a. Side views showing Patient 1's bite, or adequate smile view photographs;
    b. Diagnostic radiographs;
    c. An orthodontic analysis;
    d. A problem list;
    e. An objective list; or
    f. A sufficient or appropriate treatment plan.

16. The Registrant did not retain a copy of the digital models on which Patient 1's treatment was based, and he permitted the models to be retained by a third-party company that revoked his access to records of dental treatment he provided to patients.

Expert Report

17. The College retained an expert, Dr. Pavel Sectakof, to review the Registrant’s treatment of Patient 1. Dr. Sectakof opined that, in his treatment of Patient 1, the Registrant failed to maintain the standards of practice of the profession, provided treatment that was beyond his expertise or competence and failed to obtain consent to treatment. In addition, Dr. Sectakof opined that the Registrant failed to maintain records as required.

Patient 2 – JM

18. In July 2019, Patient 2 sought orthodontic treatment from the Registrant, through the SDC platform. Patient 2 received treatment from the Registrant from 2019 to 2021.

19. Over the course of Patient 2's treatment, and despite being the dentist responsible for Patient 2's treatment, the Registrant never met or communicated directly with Patient 2.

Informed consent

20. The Registrant failed to obtain informed consent prior to commencing treatment. SDC only obtained an executed generic "informed consent" form. The Registrant delegated his responsibility to obtain Patient 2's consent to treatment to administrative staff and never communicated with Patient 2 directly to obtain their informed consent to treatment. Patient 2 was required to sign a generic consent form at the same appointment when scans were taken and before Patient 2 had an opportunity to review the images depicting the projected treatment outcome.

21. The Registrant did not discuss a treatment plan with Patient 2. The Registrant did not discuss the risks, benefits, side effects or alternatives to treatment with Patient 2 before beginning the treatment. Specifically, the Registrant did not discuss the risks that an ideal treatment outcome might not be achievable, and that the proposed treatment could push teeth out of the arch.

22. The Registrant himself did not recommend that Patient 2 consult an orthodontist to discuss alternative treatment options, including more advanced orthodontic treatment options.

23. It is agreed that the failure to obtain informed consent through a personal interaction with Patient 2 also constitutes a failure to maintain the standards of practice of the profession.

Failure to Maintain the Standards of Practice of the Profession

24. In addition to the conduct described in paragraphs 19 to 22 above, it is agreed that in his treatment of Patient 2, the Registrant further failed to maintain the standards of practice of the profession in the following ways:

    a. the Registrant diagnosed Patient 2 with a Class I occlusion when Patient 2 likely had a Class III right molar and Class II bilateral cuspid malocclusion with a lingual crossbite on the right second mandibular premolar, and midline discrepancy;
    b. The Registrant's case work-up was incomplete because he did not perform a sufficient orthodontic analysis or take any diagnostic radiographs and did not create or provide Patient 2 a sufficient or appropriate treatment plan for their orthodontic treatment;

c. The Registrant did not adequately monitor Patient 2's orthodontic process during the treatment to assess whether detrimental changes were occurring. Patient 2 uploaded "check-in" photos to the SDC platform. Along with the photos, Patient 2 submitted clinical questions about their treatment progress. The Registrant failed to respond to Patient 2's clinical questions and never communicated directly with Patient 2, even when Patient 2 requested to speak with the Registrant directly about their treatment. Patient 2 ultimately discontinued their treatment with the Registrant and requested a refund because they were not able to speak with the Registrant; and
d. the Registrant provided treatment that did not result in an outcome acceptable to Patient 2.

The Registrant provided treatment that was beyond his expertise or competence

25. The Registrant ought to have known that Patient 2's case was complex and was not suitable for the type of clear aligner therapy that the Registrant provided. Notwithstanding the complexity of Patient 2's case, the Registrant did not refer Patient 2 to an orthodontist for consultation and treatment.

26. The Registrant did not understand the potential effects of the treatment he provided on Patient 2's occlusion. The Registrant thought that the tooth movement in this case was "minor", when in fact it risked pushing Patient 2's teeth out of the arch and risked having a significant detrimental impact on Patient 2's bite.

Failure to Keep Records as Required

27. The Registrant's records for Patient 2 were incomplete, and did not include:

    a. Side view pictures showing Patient 2's bite;
    b. Interdigitated scans;
    c. Diagnostic radiographs;
    d. An orthodontic analysis;
    e. A problem list;
    f. An objective list; or
    g. A sufficient or appropriate treatment plan.

28. The Registrant did not retain a copy of the digital models on which Patient 2's treatment was based, and he permitted the models to be retained by a third-party company that revoked his access to records of dental treatment he provided to patients.

Expert Report

29. The College retained an expert, Dr. Pavel Sectakof, to review the Registrant's treatment of Patient 2. Dr. Sectakof opined that, in his treatment of Patient 2, the Registrant failed to maintain the standards of practice of the profession, provided treatment that was beyond his expertise or competence and failed to obtain consent to treatment. In addition, Dr. Sectakof opined that the Registrant failed to maintain records as required.

Patient 3 – SC

30. In November 2018, Patient 3 sought orthodontic treatment from the Registrant, through the SDC platform. Patient 3 received treatment from the Registrant from 2018 to 2019.

31. Over the course of Patient 3's treatment, and despite being the dentist responsible for their treatment, the Registrant never met or communicated directly with Patient 3.

Informed Consent

32. The Registrant failed to obtain informed consent to treatment prior to commencing treatment. SDC only obtained an executed generic "informed consent" form. The Registrant delegated his responsibility to obtain Patient 3's consent to treatment to administrative staff and never communicated with Patient 3 directly to obtain their informed consent to treatment, or about their treatment more broadly and allow for an opportunity to ask questions.

33. Patient 3 was required to sign a generic consent form before impressions were taken, and before Patient 3 was able to see the images showing their projected results.

34. The Registrant did not discuss any treatment plan with Patient 3, nor did he discuss the risks, benefits, side effects and alternatives of the orthodontic treatment with Patient 3 before beginning the treatment. In particular, the Registrant did not personally discuss with Patient 3 the specific risks that the treatment could result in a larger open bite and negative overjet, and the impact that such outcomes could have on Patient 3.

35. The Registrant himself did not recommend that Patient 3 consult an orthodontist to discuss alternative treatment options, including more advanced orthodontic treatment options.

36. It is agreed that the failure to obtain informed consent through a personal interaction with Patient 3 also constitutes a failure to maintain the standards of practice of the profession.

Failure to Maintain the Standards of Practice of the Profession

37. In addition to the conduct described in paragraphs 31-35 above, it is agreed that in his treatment of Patient 3, the Registrant further failed to maintain the standards of practice of the profession in the following ways:

    a. the Registrant's case work-up was incomplete, the Registrant did not perform a sufficient orthodontic analysis or take any necessary diagnostic radiographs and did not create or provide Patient 3 with a sufficient or appropriate treatment plan for their orthodontic treatment;

b. the Registrant diagnosed Patient 3 with a Class II malocclusion when they likely had a complex Class III malocclusion; and
c. the Registrant did not adequately monitor Patient 3's orthodontic progress during the treatment to assess whether detrimental changes were occurring. When Patient 3 did not attend “check-in” appointments after 90 and 180 days of treatment, the Registrant did not personally follow up with Patient 3.

The Registrant provided treatment that was beyond his expertise or competence

38. The Registrant ought to have known that Patient 3’s case was complex and was not suitable for the type of clear aligner therapy that the Registrant provided. In addition, the Registrant provided treatment that he ought to have known would result in a larger open bite and negative overjet, and would leave Patient 3 with a nonfunctional bite. The Registrant did not understand the potential effects of his treatment on Patient 3’s occlusion. He thought the tooth movement in this case was “minor” when it had a significant detrimental impact on Patient 3’s bite.

39. The Registrant did not refer Patient 3 to an orthodontist for consultation and treatment.

Failure to Keep Records as Required

40. The Registrant’s records for Patient 3 were incomplete, and did not include the following:

    a. Interdigitated scans that showed Patient 3's bite;
    b. Diagnostic radiographs;
    c. An orthodontic analysis;
    d. A problem list;
    e. An objective list; or
    f. A sufficient or appropriate treatment plan.

41. The Registrant did not retain a copy of the digital models on which Patient 3’s treatment was based, and he permitted the models to be retained by a third-party company that revoked his access to records of dental treatment he provided to patients.

Expert Report

42. The College retained an expert, Dr. Pavel Sectakof, to review the Registrant’s treatment of Patient 3. Dr. Sectakof opined that, in his treatment of Patient 3, the Registrant failed to maintain the standards of practice of the profession, provided treatment that was beyond his expertise or competence and failed to obtain consent to treatment. In addition, Dr. Sectakof opined that the Registrant failed to maintain records as required.

NOTICE OF HEARING 24-0313

Patient 4 – GG

43. In February, 2019, Patient 4 sought orthodontic treatment from the Registrant, through the SDC platform. Patient 4 received treatment from the Registrant from 2019 to 2020.

44. Over the course of Patient 4's treatment, and despite being the dentist responsible for Patient 4's treatment, the Registrant never met or communicated directly with Patient 4.

Failure to obtain informed consent

45. The Registrant failed to obtain informed consent to treatment prior to commencing treatment. SDC only obtained an executed generic "informed consent" form. The Registrant delegated his responsibility to obtain Patient 4's consent to treatment to administrative staff and never communicated directly with Patient 4 to obtain their informed consent to treatment.

46. Patient 4 was required to sign a generic consent form at the same appointment when scans were taken and before Patient 4 had an opportunity to review the images depicting the projected treatment outcome.

47. The Registrant did not personally discuss any treatment plan with Patient 4. The Registrant did not discuss the risks, benefits, side effects and alternatives of the orthodontic treatment with Patient 4 before beginning the treatment. He did not personally discuss the specific risks that the treatment could result in a posterior or anterior open bite, and the impacts that these outcomes could have on Patient 4.

48. The Registrant himself did not recommend that Patient 4 consult an orthodontist to discuss alternative treatment options, including more advanced orthodontic treatment options.

49. It is agreed that the failure to obtain informed consent through a personal interaction with Patient 4 also constitutes a failure to maintain the standards of practice of the profession.

Failure to Maintain the Standards of Practice of the Profession

50. In addition to the conduct described in paragraphs 44-48 above, it is agreed that in his treatment of Patient 4, the Registrant further failed to maintain the standards of practice of the profession in the following ways:

    a. the Registrant failed to diagnose Patient 4's occlusion and failed to make any diagnostic statement in Patient 4's records;
    b. the Registrant's case work-up was incomplete because he did not perform a sufficient orthodontic analysis or take any diagnostic radiographs and did not create or provide Patient 4 with a sufficient or appropriate treatment plan for their orthodontic treatment;

c. the Registrant did not adequately monitor Patient 4's orthodontic progress during the treatment to assess whether detrimental changes were occurring;
d. Patient 4 uploaded, through the SDC platform, photographs detailing their progress with treatment. The Registrant did not review the photographs;
e. the Registrant provided treatment that created a posterior open bite for Patient 4 and offered refinement treatment to Patient 4 that he ought to have known would create an anterior open bite; and
f. the Registrant did not communicate directly with Patient 4 at all during the treatment, even when Patient 4 raised clinical concerns about the impact that the treatment was having on their bite. SDC staff reviewed Patient 4's bite issues and made recommendations without the Registrant's involvement.

The Registrant provided treatment that was beyond his expertise or competence

51. The Registrant ought to have known that Patient 4's case was complex and was not suitable for the type of clear aligner therapy that he provided. The Registrant should have referred Patient 4 to an orthodontist for consultation and treatment.

52. The Registrant did not understand the potential effects of his treatment on Patient 4's occlusion.

53. The Registrant thought that the tooth movement in this case was "minor" when it had a significant detrimental impact on Patient 4's bite.

Failure to Keep Records as Required

54. The Registrant's records for Patient 4 were incomplete, and did not include:

    a. Interdigitated scans that showed Patient 4's bite;
    b. Diagnostic radiographs;
    c. An orthodontic analysis;
    d. A problem list;
    e. An objective list; or
    f. A sufficient or appropriate treatment plan.

55. The Registrant did not retain a copy of the digital models on which Patient 4's treatment was based, and permitted the models to be retained by a third-party company that revoked the Registrant's access to records of dental treatment he provided to patients.

Expert Report

56. The College retained an expert, Dr. Pavel Sectakof, to review the Registrant's treatment of Patient 4. Dr. Sectakof opined that, in his treatment of Patient 4, the Registrant failed to maintain the standards of practice of the profession, provided treatment that was beyond his expertise or competence and failed to obtain consent to treatment. In addition, Dr. Sectakof opined that the Registrant failed to maintain records as required.

NOTICE OF HEARING 24-0314

Patient 5 – DA

57. In December, 2018, Patient 5 sought orthodontic treatment from the Registrant, through the SDC platform. Patient 5 received treatment from the Registrant from 2018 to 2020.

58. Over the course of Patient 5's treatment, and despite being the dentist responsible for their treatment, the Registrant never met or communicated directly with Patient 5.

Informed Consent

59. The Registrant failed to obtain informed consent to treatment prior to commencing treatment. SDC only obtained an executed generic "informed consent" form. The Registrant delegated his responsibility to obtain Patient 5's consent to treatment to administrative staff and never communicated with Patient 5 directly to obtain their informed consent to treatment.

60. Patient 5 was required to sign a generic consent form at the same appointment when scans were taken and before Patient 5 had an opportunity to review the images depicting the projected treatment outcome.

61. The Registrant did not discuss any treatment plan with Patient 5. The Registrant did not discuss the risks, benefits, side effects, and alternatives of the orthodontic treatment with Patient 5 before beginning the treatment. He did not personally discuss the specific risks that the treatment could worsen Patient 5's posterior bite and the impacts that these outcomes could have on Patient 5.

62. The Registrant himself did not recommend that Patient 5 consult an orthodontist to discuss alternative treatment options, including more advanced orthodontic treatment options.

63. It is agreed that the failure to obtain informed consent through a personal interaction with Patient 5 also constitutes a failure to maintain the standards of practice of the profession.

Failure to Maintain the Standards of Practice of the Profession

64. In addition to the conduct described in paragraphs 58-62 above, it is agreed that in his treatment of Patient 5, the Registrant further failed to maintain the standards of practice of the profession in the following ways:

    a. the Registrant's diagnosis of Patient 5 was incomplete and did not include relevant complicating factors, including Patient 5's peg-shaped tooth, missing incisor, midline discrepancy, crossbite or diastema;
    b. the Registrant treated Patient 5 without a clear understanding of Patient 5's chief complaint;

c. the Registrant's case work-up was incomplete because he did not perform a sufficient orthodontic analysis or take any necessary diagnostic radiographs and did not create or provide Patient 5 with a sufficient or appropriate treatment plan for their orthodontic treatment;
d. the Registrant did not adequately monitor Patient 5's orthodontic progress during the treatment to assess whether detrimental changes were occurring. The Registrant did not follow up personally with Patient 5 when they did not "check-in" after 90 or 180 days of treatment;
e. the Registrant provided treatment that worsened Patient 5's bite;
f. the Registrant did not communicate directly with Patient 5 at all during the treatment, even when Patient 5 raised clinical concerns about the fit of their aligners and raised questions about whether a dentist was overseeing their treatment at all. Instead, SDC staff repeatedly directed Patient 5 to re-submit pictures of their teeth; and
g. the Registrant did not clarify with Patient 5 or ask any follow-up questions about whether Patient 5 had recently had x-rays with their regular dentist, despite Patient 5 answering this question inconsistently on two different forms.

The Registrant provided treatment that was beyond his expertise or competence

65. The Registrant ought to have known Patient 5's case was complex and was not suitable for the type of clear aligner therapy that he provided. The Registrant should have referred Patient 5 to an orthodontist for consultation and treatment.

66. The Registrant did not understand the potential effects of his treatment on Patient 5's occlusion. The Registrant thought that the tooth movement in this case was "minor" when it had a significant detrimental impact on Patient 5's bite.

Failure to Keep Records as Required

67. The Registrant's records for Patient 5 were incomplete, and did not include:

a. Side bite pictures;
b. Diagnostic radiographs;
c. An orthodontic analysis;
d. A problem list;
e. An objective list; or
f. A sufficient or appropriate treatment plan.

68. The Registrant did not retain a copy of the digital models on which Patient 5's treatment was based, and permitted the models to be retained by a third-party company that revoked the Registrant's access to records of dental treatment he provided to patients.

Expert Report

69. The College retained an expert, Dr. Pavel Sectakof, to review the Registrant's treatment of Patient 5. Dr. Sectakof opined that, in his treatment of Patient 5, the Registrant failed to maintain the standards of practice of the profession, provided

treatment that was beyond his expertise or competence and failed to obtain consent to treatment. In addition, Dr. Sectakof opined that the Registrant failed to maintain records as required.

NOTICE OF HEARING 25-0440

Patient 6 – DH

70. In August, 2022, Patient 6 sought orthodontic treatment from the Registrant, through the SDC platform. Patient 6 received treatment from the Registrant from 2022 to 2023.

71. Over the course of Patient 6’s treatment, and despite being the dentist responsible for their treatment, the Registrant never met or communicated directly with Patient 6.

Informed Consent

72. The Registrant failed to obtain informed consent to treatment prior to commencing treatment. SDC only obtained an executed generic “informed consent” form. The Registrant delegated his responsibility to obtain Patient 6's consent to treatment to administrative staff and never communicated with Patient 6 directly to obtain their informed consent to treatment, or about their treatment more broadly and allow for an opportunity to ask questions.

73. The Registrant did not discuss any treatment plan with Patient 6, nor did he discuss the treatment modalities, risks, benefits and alternatives of the orthodontic treatment with Patient 6 before beginning the treatment.

74. The Registrant himself did not recommend that Patient 6 consult an orthodontist and/or a periodontist to discuss alternative treatment options.

75. It is agreed that the failure to obtain informed consent through a personal interaction with Patient 6 also constitutes a failure to maintain the standards of practice of the profession.

Failure to Maintain the Standards of Practice of the Profession

76. In addition to the conduct described in paragraphs 71-74 above, it is agreed that in his treatment of Patient 6, the Registrant further failed to maintain the standards of practice of the profession in the following ways:

    a. the Registrant did not discuss the risks, benefits, side effects, and alternatives of the orthodontic treatment with Patient 6 before beginning the treatment;
    b. the Registrant diagnosed Patient 6 with Class II division 1 mild crowding in the upper arch, heavy crowding in the lower arch, normal overbite and overjet, with no crossbite when Patient 6 likely had a Class I malocclusion with mild overjet and a very deep impinging bite;
    c. the Registrant’s case work-up was incomplete because he did not perform a sufficient orthodontic analysis and did not create or provide Patient 6 with a

sufficient or appropriate treatment plan for their orthodontic treatment, nor was there any verbal discussion about a treatment plan with Patient 6;

d. the Registrant did not adequately monitor Patient 6's orthodontic progress during the treatment to assess whether detrimental changes were occurring. There was no indication that the Registrant monitored Patient 6 or was aware that Patient 6 had concerns about her treatment even after Patient 6 informed SDC about increased tooth mobility. There was no attempt by the Registrant to contact Patient 6 to discuss Patient 6's concerns, nor was Patient 6 clinically assessed at 90 days or checked periodically to assess damage to their teeth or supporting structures; and
e. the Registrant failed to maintain Patient 6's records as required.

The Registrant provided treatment that was beyond his expertise or competence

77. The Registrant ought to have known that Patient 6 was not an appropriate candidate for the type of clear aligner therapy that he provided. The Registrant should have referred Patient 6 to an orthodontist for consultation and treatment given her periodontal bone loss and very deep bite.

78. The Registrant did not understand the potential effects of his treatment on Patient 6's bite.

Failure to Keep Records as Required

79. It is agreed that the Registrant failed to maintain Patient 6's records as required. The Registrant's records for Patient 6 were incomplete, and did not include:

    a. A problem list, objective list or a sufficient or appropriate treatment plan;
    b. Side bite views;
    c. Scans that were interdigitated and showed Patient 6's bite; or
    d. X-rays for Patient 6.

80. The Registrant did not retain a copy of the digital models on which Patient 6's treatment was based, and permitted the models to be retained by a third-party company that revoked the Registrant's access to records of dental treatment he provided to patients.

Expert Report

81. The College retained an expert, Dr. Pavel Sectakof, to review the Registrant's treatment of Patient 6. Dr. Sectakof opined that, in his treatment of Patient 6, the Registrant failed to maintain the standards of practice of the profession, provided treatment that was beyond his expertise or competence and failed to obtain consent to treatment. In addition, Dr. Sectakof opined that the Registrant failed to maintain records as required.

Patient 7 – IO

82. In January, 2020, Patient 7 sought orthodontic treatment from the Registrant, through the SDC platform. Patient 7 received treatment from the Registrant from 2020 to 2021.

83. Over the course of Patient 7's treatment, and despite being the dentist responsible for their treatment, the Registrant never met or communicated directly with Patient 7.

Informed Consent

84. The Registrant failed to obtain informed consent to treatment prior to commencing treatment. SDC only obtained an executed generic "informed consent" form. The Registrant delegated his responsibility to obtain Patient 7's consent to treatment to administrative staff and never communicated with Patient 7 directly to obtain their informed consent to treatment.

85. The Registrant did not discuss any treatment plan with Patient 7, nor did he verbally discuss the treatment modalities, including possible orthognathic surgery, risks, benefits and alternatives of the orthodontic treatment with Patient 7 before beginning the treatment.

86. The Registrant himself did not recommend that Patient 7 consult an orthodontist to discuss alternative treatment options.

87. It is agreed that the failure to obtain informed consent through a personal interaction with Patient 7 also constitutes a failure to maintain the standards of practice of the profession.

Failure to Maintain the Standards of Practice of the Profession

88. In addition to the conduct described in paragraphs 83-86 above, it is agreed that in his treatment of Patient 7, the Registrant further failed to maintain the standards of practice of the profession in the following ways:

    a. the Registrant did not identify a problem list, objective list or a sufficient or appropriate treatment plan;

    b. the Registrant diagnosed Patient 7 with Class II division 1 moderate spacing in the upper arch, heaving spacing in the lower arch, an anterior open bite, an edge to edge overjet and no crossbite when they likely had a Class I or Class III dentoalveolar and skeletal malocclusion with maxillary and mandibular spacing, a severe openbite, proclined maxillary and mandibular incisors and a posterior bilateral crossbite;

    c. the Registrant did not adequately monitor Patient 7's orthodontic progress during the treatment to assess whether detrimental changes were occurring, including after Patient 7 raised concerns about treatment. Patient 7 was not clinically

assessed at 90 days or checked periodically to assess damage to Patient 7's teeth or supporting structures; and

d. the Registrant provided treatment he ought to have known would have a detrimental impact on Patient 7's bite.

The Registrant provided treatment that was beyond his expertise or competence

89. The Registrant ought to have known that Patient 7 was not an appropriate candidate for the type of clear aligner therapy he provided given Patient 7's severe underlying skeletal problem. Treatment by a specialist and possible orthognathic surgery should have been considered.

90. The Registrant did not understand the potential effects of his treatment on Patient 7's bite. The Registrant should have referred Patient 7 to an orthodontist for consultation and treatment.

Failure to Keep Records as Required.

91. The Registrant failed to keep records as required. The Registrant's records for Patient 7 were incomplete, and did not include:

    a. A problem list, objective list, or a sufficient or appropriate treatment plan;
    b. Side bite views;
    c. X-rays for Patient 7; or
    d. Scans that were interdigitated and showed Patient 7's bite.

92. The Registrant did not retain a copy of the digital models on which Patient 7's treatment was based and permitted the models to be retained by a third-party company that revoked the Registrant's access to records of dental treatment he provided to patients.

Expert Report

93. The College retained an expert, Dr. Pavel Sectakof, to review the Registrant's treatment of Patient 7. Dr. Sectakof opined that, in his treatment of Patient 7, the Registrant failed to maintain the standards of practice of the profession, provided treatment that was beyond his expertise or competence and failed to obtain consent to treatment. In addition, Dr. Sectakof opined that the Registrant failed to maintain records as required.

Guidelines

94. It is agreed that between 2018 and 2024, the College's *Guidelines on Dental Recordkeeping* were in force. Enclosed hereto as **Tab "B"** are the versions that were in force over the material time.

Professional Misconduct Admitted

95. By this document, the Registrant admits to the truth of the facts referred to in paragraphs 1 to 94 above (the "**Agreed Facts**").

96. It is agreed that the Agreed Facts constitute professional misconduct pursuant to the following:

    a. Section 51(1)(c) of the Code, and as defined in the following paragraphs of section 2 of Ontario Regulation 853/93:
        i. Paragraph 1: Contravening a standard of practice or failing to maintain the standards of practice of the profession;
        ii. Paragraph 5: Treating or attempting to treat a disease, disorder or dysfunction of the oral-facial complex that the member knows or ought to know is beyond his or her expertise or competence;
        iii. Paragraph 7: Treating a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent; and
        iv. Paragraph 25: Failing to keep records as required by the regulations."

DECISION

[11] The Panel deliberated and considered the evidence, including the admissions made by Dr. Kliman in the ASF, and the submissions of the parties. The Panel found that the College proved the allegations of professional misconduct against Dr. Kliman on a balance of probabilities. The Chair announced the Panel's decision on the record.

REASONS FOR DECISION

[12] The College bears the onus of proving the allegations against the Registrant on a balance of probabilities through clear, cogent and convincing evidence. The Registrant's admissions of professional misconduct are material but must be supported by evidence. The Panel found that the evidence contained in the global ASF supports the Registrant's admissions and satisfies the College's burden of proof.

Allegation 1: **Contravening a standard of practice - failing to maintain the standards of the profession.**

[13] The first series of allegations admitted by Dr. Kliman – that he contravened a standard of practice or failed to maintain the standards of the profession, contrary to section 51(1)(c) of the Code and section 2(1) of the Professional Misconduct Regulation – applied across all seven patients.

[14] The Panel accepted Dr. Kliman's admissions and found that the facts as set forth in the ASF support a finding of professional misconduct on this ground. The Panel is concerned that Dr. Kliman failed to maintain the standards of the profession repeatedly and in many different ways. Many of the standards contraventions admitted by Dr. Kliman with respect to all seven (7) patients are identical or similar. They include:

(a) That he misdiagnosed his patients;
(b) That his diagnosis of his patients was incomplete and did not include relevant complicating factors;
(c) That his case work-up was incomplete;
(d) That he did not adequately monitor his patients' orthodontic progress;
(e) That he did not follow up with his patient(s) when they did not "check in" after 90 or 180 days of treatment;
(f) That he did not discuss the risks, benefits, side effects, and alternatives of the orthodontic treatment with his patient(s) before beginning treatment;
(g) That he did not discuss with his patient(s) the specific risks that the treatment could result in an open or edge-to-edge bite and parafunction and the impact that this outcome would have on the patient(s). In particular, he did not explain to his patient(s) what an open bite is;
(h) That he did not recommend to his patient(s) that they consult an orthodontist to discuss alternative treatment options;
(i) That his patients were required to sign an informed consent form at the same appointment when scans were taken and before the patients had an opportunity to review the images depicting the projected treatment outcome; and
(j) That he delegated his responsibility to obtain the patients' informed consent to treatment to administrative staff and did not at any point communicate with the patients directly about their informed consent to treatment.

Allegation 2: Treating patients beyond the dentist's level of competence

[15] The second series of allegations admitted by Dr. Kliman – that he treated or attempted to treat a disease, disorder or dysfunction of the oral-facial complex that he knew or ought to have known was beyond his expertise or competence, contrary to section 51(1)(c) of the Code and section 2(5) of the Professional Misconduct Regulation – similarly applied across all seven patients.

[16] The Panel accepted Dr. Kliman's admissions and found that the facts as set forth in the ASF support a finding of professional misconduct on this ground. The Panel considered this misconduct to be particularly serious. Further, the Panel is concerned that Dr. Kliman engaged in this type of professional misconduct repeatedly and in different respects. For example, with respect to Patients LS, SC, JM, GG, and DA, Dr. Kliman admitted that he:

(a) Knew or ought to have known that his patients' cases were complex and were not suitable for the type of clear aligner therapy that he provided;
(b) Did not refer the patients to an orthodontist for consultation and/or treatment;
(c) Thought the tooth movement in each case was "minor" when it had a significant detrimental impact on these patients; and
(d) Thought that an open bite was beneficial to the patients.

[17] The Panel also accepted Dr. Kliman's admissions under this ground with respect to patients DH and IO. The particulars in these cases differed from those in the five (5) cases above. Dr. Kliman admitted, with respect to these two patients, that he:
(a) Knew or ought to have known that his patients were not appropriate candidates for orthodontic aligner treatment and that it was not appropriate for these patients

to be treated by a general dentist in the circumstances of each case. More particularly, Patient DH had periodontal bone loss and a very deep bite; Patient IO had a severe underlying skeletal problem and treatment by a specialist and possible orthognathic surgery should have been considered;

(b) Did not understand the potential effects of his treatment on his patients' bites; and

(c) Did not refer the patients to an orthodontist for consultation and/or treatment.

[18] Dr. Kliman's admissions were unrefuted evidence that he had committed the misconduct detailed by the College in the ASF. The Panel therefore found that Dr. Kliman committed professional misconduct under the second set of allegations.

Allegation 3: Failure to obtain informed consent

[19] The third series of allegations admitted by Dr. Kliman – that he treated his patients for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such consent, contrary to section 51(1)(c) of the Code and section 2(7) of the Professional Misconduct Regulation – also applied across all seven (7) patients.

[20] The Panel accepted Dr. Kliman's admissions and found that the facts as set forth in the ASF support a finding of professional misconduct on this ground.

[21] More particularly, with respect to patients LS, SC, JM, GG, and DA, Dr. Kliman admitted and the Panel found that he:

(a) Did not discuss the risks, benefits, side effects, and alternatives of the orthodontic treatment with his patients before beginning treatment;

(b) Did not discuss the specific risks of the treatment with each of his patients;

(c) Did not recommend that his patients consult an orthodontist to discuss alternative treatment options, including more advanced orthodontic treatment options;

(d) Required the patients to sign an informed consent form at the same appointment when scans were taken and before the patients had an opportunity to review the images depicting the project treatment outcome;

(e) Did not discuss a treatment plan with his patients; and

(f) Delegated his responsibility to obtain his patients' informed consent to treatment to administrative staff and did not communicate with his patients directly about their informed consent to treatment.

[22] With respect to patients DH and IO, Dr. Kliman admitted and the Panel found that Dr. Kliman:

(a) Did not discuss the treatment modalities, risks, benefits and alternatives of orthodontic treatment with these patients before beginning treatment;

(b) Did not discuss any treatment plan with these patients;

(c) Did not recommend that the patients consult an orthodontist and/or a periodontist to discuss alternative treatment options; and

(d) Delegated his responsibility to obtain his patients' informed consent to treatment to administrative staff and did not communicate with his patients directly about their informed consent to treatment

Allegation 4: Failing to keep records, as required

[23] The fourth series of allegations admitted by Dr. Kliman – that he failed to keep records as required by sections 38(b) and/or 38(c) of Regulation 547, RRO 1990, contrary to section 2(25) of the Professional Misconduct Regulation – also applied across all seven (7) patients.

[24] More particularly, with respect to patients LS, SC, JM, GG, DA, DH and IO Dr. Kliman admitted, and the Panel found, that his records for his patients did not include:

(a) Side views of the patients' bite;
(b) Interdigited scans that showed the patients' bite;
(c) Diagnostic radiographs;
(d) An orthodontic analysis;
(e) A problem list;
(f) An objective list; or
(g) A treatment plan.

[25] Further with respect to Patients DH and IO, Dr. Kliman admitted and the Panel found that his patients' records did not include x-rays for the patients. It was alleged by the College, and Dr. Kliman admitted, that he failed to maintain the patients' records as required.

[26] Again, this is not a situation of a single incident of poor judgment or poor record-keeping. These acts of professional misconduct occurred over a period of several years and across several patients. They took place beginning in 2018-19 (Patients SC and DA) and continuing until 2022-23 (Patient DH).

[27] The Panel is thus satisfied, on a balance of probabilities, that Dr. Kliman engaged in serious professional misconduct when he offered clear aligner therapy treatments utilizing the SDC platform to patients in circumstances where he failed to comply with the regulatory requirement to keep patient records.

[28] Viewed in its totality, the Panel was concerned that Dr. Kliman's conduct has significantly undermined the trust relationship that exists between dentists and their patients, the College and the public.

PENALTY SUBMISSIONS

[29] The parties presented the Panel with a global Joint Submission with respect to Penalty and Costs ("**JSPC**") (Exhibit 10) and asked the Panel to make an order as follows:

1. "The Royal College of Dental Surgeons of Ontario (the "**College**") and Dr. Kevin Kliman (the "**Registrant**") jointly submit that this panel of the Discipline Committee impose the following penalty on the Registrant as a result of the panel's finding that the Registrant is guilty of professional misconduct, namely, that it make an order:

    a) requiring the Registrant to appear before the panel of the Discipline Committee to be reprimanded within ninety (90) days of this Order becoming final or on a date fixed by the Registrar;

b) directing the Registrar to suspend the Registrant's certificate of registration for a period of twelve (12) months, commencing at 12:01 am on the day after this Order. The suspension shall run without interruption;

c) requiring the Registrar to impose the following terms, conditions and limitations on the Registrant's certificate of registration (the "**Suspension Conditions**"), which Suspension Conditions shall continue until the suspension of the Registrant's certificate of registration, as referred to in paragraph 1(b) above, has been fully served:

   (i) while the Registrant's certificate of registration is under suspension, the Registrant shall immediately inform the following people about the suspension:

      1. staff in the offices or practices in which the Registrant works, including other regulated professionals and administrative staff;
      2. dentists with whom the Registrant works, whether the Registrant is a principal in the practice or otherwise associated with the practice;
      3. dentists or other individuals who routinely refer patients to the Registrant;
      4. faculty members at Faculties of Dentistry, if the Registrant is affiliated with the Faculty in an academic or professional capacity;
      5. owners of a practice or office in which the Registrant works;
      6. patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Registrant may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

   (ii) while suspended, the Registrant must not engage in the practice of dentistry, including but not limited to:

      1. acting in any manner that suggests the Registrant is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Registrant must ensure that administrative or office staff do not suggest to patients in any way that the Registrant is entitled to engage in the practice of dentistry;
      2. giving orders or standing orders to dental hygienists;
      3. supervising work performed by others;
      4. working in the capacity of a dental assistant or performing laboratory work;
      5. acting as a clinical instructor;

   (iii) while suspended, the Registrant must not be present in offices or practices where the Registrant works when patients are present, except for emergencies that do not involve patients. The Registrant must immediately advise the Registrar in writing about any such emergencies;

   (iv) while suspended, the Registrant must not benefit or profit, directly or

indirectly from the practice of dentistry and

1. the Registrant may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Registrant may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period;
2. the Registrant is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension;
3. the Registrant must not sign insurance claims for work that has been completed by others during the suspension period;

(v) the Registrant shall cooperate with any office monitoring which the Registrar thinks is needed to ensure that the Registrant has complied with the Suspension Conditions. The Registrant must provide the College with access to any records associated with the practice that the College may require to verify that the Registrant has not engaged in the practice of dentistry or profited during the suspension; and

(vi) the Suspension Conditions imposed by virtue of subparagraphs 1(c)(i)-(v) above shall be removed at the end of the period that the Registrant's certificate of registration is suspended.

d) directing that the Registrar also impose the following additional terms, conditions and limitations on the Registrant's Certificate of Registration, namely:

(i) That the Registrant be permanently restricted from providing orthodontic treatment to patients;

(ii) The Registrant shall successfully complete, at his own expense, the following courses and instruction within six (6) months of this Order becoming final or such further time as may be permitted by the Registrar:

1. The Ontario Dental Association's course on informed consent, pre-approved by the College, with written proof of successful completion provided to the College;
2. An ethics course, pre-approved by the College, with written proof of successful completion provided to the College; and
3. The College's Recordkeeping Fundamentals course, with proof of successful completion provided to the College.

(iii) The Registrant shall successfully complete, at his own expense, the following courses and instruction within twelve (12) months of this Order becoming final or such further time as may be permitted by the Registrar:

1. The College's Applied Recordkeeping course, with written proof of successful completion provided to the College.

(iv) That following the completion of the suspension of the Registrant's certificate of registration, as referred to in paragraph 1(b) above, the Registrant shall retain, at his own expense, a qualified dentist, pre-approved by the College, to act as his Clinical Supervisor for a minimum of 12 months (the "**Clinical Supervisor**"). The Registrant will ensure that his Clinical Supervisor provides the College with a signed copy of the Clinical Supervisor's Undertaking attached as Appendix "A" to this Order.

(v) The Registrant will practise under Clinical Supervision at Level 1 as specified in the Clinical Supervision Framework attached as Appendix "B" to this Order. The Level of Clinical Supervision will not be reduced, nor will Clinical Supervision end, without the recommendation of the Clinical Supervisor and only with the College's prior approval, in writing.

(vi) The Registrant shall abide by all recommendations of the Clinical Supervisor, including recommendations for changes to his practice and taking any course or reviewing any resources recommended by the Clinical Supervisor.

(vii) The Registrant shall ensure that the Clinical Supervisor completes all the requirements of the Clinical Supervision set out below, including providing required reports to the College, as outlined in this Order, in a timely manner.

(viii) During Level 1 Clinical Supervision, the Clinical Supervisor will:

1. Be available to the Registrant at scheduled times, in-person or electronically, to discuss the Registrant's recordkeeping and informed consent practices;
2. Review at least 15 of the Registrant's patient charts for recordkeeping and informed consent to treatment each month and discuss with him any recommendations with respect to his recordkeeping and informed consent practices. If fewer than 15 patient charts are available for any given month, the Clinical Supervisor will review all the Registrant's patient charts for recordkeeping and informed consent for that month. If the Registrant does not see any patients in a given month, to be confirmed by production summaries, no chart review is required; and
3. Provide a report to the College every three months in the format specified by the College.

(ix) The Registrant shall be subject to Clinical Supervision for a minimum of twelve (12) months. Prior to recommending that the Registrant be permitted to practise without Clinical Supervision, the Clinical Supervisor shall:

1. conduct chart reviews for at least 15 patient visits over at least a three-month period, 4 separate times (12 months total); and
2. confirm to the College, in writing, that both the Clinical Supervisor and the Registrant are confident that the Registrant's recordkeeping and informed consent practices are satisfactory and that he can practise dentistry without the need for Clinical Supervision.

(x) At any time during Clinical Supervision, the Clinical Supervisor will report to the College immediately if:

1. the Clinical Supervisor believes that the Registrant's conduct or treatment is likely to expose his patients to harm or injury;
2. the Registrant has breached the terms of this Order, or any terms, conditions or limitations placed on the Registrant's certificate of registration;

3. the Clinical Supervisor believes that the Registrant has engaged in professional misconduct;
4. any patient or staff member expresses concerns to the Clinical Supervisor about improper care or conduct by the Registrant;
5. a breakdown or conflict of interest has occurred in the relationship between the Registrant and the Clinical Supervisor; or
6. The Clinical Supervisor no longer wishes or is no longer able to act as the Registrant's Clinical Supervisor.

(xi) If the Clinical Supervisor is no longer able to act as the Registrant's Clinical Supervisor, the Registrant shall notify the College in writing immediately. The Registrant shall propose a replacement Clinical Supervisor (the "Replacement Clinical Supervisor"), to be approved by the College. If the Replacement Clinical Supervisor is not approved within 30 days of the Clinical Supervisor ceasing to provide Clinical Supervision, the Registrant must cease practice until he is able to retain a new Clinical Supervisor, approved by the College, to continue the Clinical Supervision.

(xii) The Registrant shall be subject to Practice Monitoring of the Registrant's practice by means of office visits by a representative of the College (the "**Practice Monitor**") during the period commencing with the date of the finalization of the Discipline Committee's order and ending thirty-six (36) months following the date the Registrant returns to practice after serving the suspension or until the Inquiries, Complaints and Reports Committee (the "**ICRC**") is satisfied that the Registrant has successfully completed the monitoring program, whichever is later.

(xiii) Practice Monitoring shall focus on the Registrant's informed consent, treatment planning and recordkeeping practices. The Practice Monitor's office visits shall be held at such time(s) as the College may determine, with advance notice to the Registrant;

(xiv) The Registrant shall cooperate with the College during the office visit(s) described above and, further, shall pay to the College in respect of the costs of monitoring, the amount of one thousand dollars ($1000.00) per visit immediately after the completion of each office visit; and

(xv) The Practice Monitor shall report the results of the office visit(s) described above to the ICRC of the College and the ICRC may, if deemed warranted, take such action as it considers appropriate.

e) that the Registrant pay costs to the College in the amount of $10,000 in respect of this discipline hearing within three (3) months of the date this Order becomes final.

2. The College and the Registrant further submit that pursuant to the Code, as amended, the results of these proceedings must be recorded on the Register of the College and any publication of the Decision of the panel would therefore occur with the name and practice address of the Registrant included."

[30] Counsel for the College made submissions based upon the content of the JSPC. In his submissions, he spoke to the penalties agreed upon by the parties and the objectives that they would achieve. He also spoke to the high bar that must be met for a panel to reject a joint submission.

PENALTY DECISION

[31] The Panel accepted the parties' JSPC and made an order (the **"Order"**) in accordance with its terms as set forth above.

REASONS FOR PENALTY DECISION

[32] Once the Discipline Committee makes findings of professional misconduct, it is incumbent upon it to impose an order that is appropriate in the circumstances. It is settled law that a decision-maker should not lightly depart from an agreement that has been reached by the parties with respect to an appropriate penalty. The test is not one of "fitness of sentence" but rather, the more stringent test of whether the jointly proposed penalty would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.[1]

[33] The Panel considered the terms of the JSPC in the context of the basic principles relating to the imposition of penalties. Those principles include that: (a) the goal of a penalty is to protect the public from dentists who have committed professional misconduct and to maintain public confidence in the profession and in its ability to self-regulate; (b) a penalty must serve as a measure of general deterrence, in that it sends a message to all registrants of the dental profession that this type of conduct will not and cannot be tolerated; (c) it must also serve as a measure of specific deterrence with respect to the dentist concerned; (d) an appropriate penalty should also provide for remediation or rehabilitation of the dentist concerned, where possible and appropriate; and lastly, (e) the penalty must be proportionate to penalties ordered in similar circumstances.

[34] The Panel must consider both mitigating and aggravating factors when assessing the appropriateness of the penalty in the circumstances.

[35] One of the more significant aggravating factors in this case was that the professional misconduct at issue took place over the course of several years. In this regard, the professional misconduct findings did not relate to a single lapse in judgement but impacted seven (7) different patients. Further, multiple findings of professional misconduct with respect to each patient were made by this panel.

[36] Of possibly greater concern, and one of the more aggravating factors among the panel's findings, was that Dr. Kliman routinely practised beyond the level of his competence and expertise and that in so doing, some of his patients were harmed.

[37] Further, the evidence established that in utilizing the SDC clear aligner therapy platform, Dr. Kliman routinely abdicated his responsibilities as a treating dentist, particularly with

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[1] *R v Anthony Cook*, 2016 SCC 43, applied in the professional discipline context in *Ontario College of Teachers v Merolle,* 2023 ONSC 3453 at para 32

respect to his responsibility for obtaining true informed consent from his patients, in ensuring that they were checked regularly at 90 and 180 days, and in ensuring that no harm was being done to his patients by the clear aligner treatment. The evidence established that at no point during the course of therapy did Dr. Kliman meet directly with his patients; all of the work was handled by assistants and the SDC platform. As College counsel said in his oral submissions, the findings with respect to Dr. Kliman's professional misconduct might well serve as a cautionary tale for other dentists who are engaging in a similar kind of practice.

[38] The College acknowledged that there were a few mitigating factors present in this case, namely that Dr. Kliman did cooperate with the investigation that led to these findings of professional misconduct. He took responsibility for his conduct.

[39] In view of the Panel's findings with respect to professional misconduct, and the aggravating and mitigating factors present in these cases, the Panel found that the penalty proposed by the parties was reasonable in the circumstances.

[40] Put simply, the Panel finds that the penalty terms proposed will together achieve the overall goals of penalty. More specifically,

Oral Reprimand

(a) The Panel ordered that Dr. Kliman appear before it to be reprimanded within ninety (90) days of the Order becoming final. A reprimand – or public denunciation of professional misconduct – has both specific and general deterrent effects and further serves to reinforce public confidence in dentistry as a self-regulated profession.

Twelve-Month Suspension

(b) The Panel ordered that Dr. Kliman's certificate of registration be suspended for a period of twelve (12) months commencing on the day after the Order was made. Suspension serves a number of the goals of penalty imposition: it offers specific deterrence in that the dentist concerned will understand how seriously the College views his misconduct and that it cannot be tolerated. It offers general deterrence in that all registrants will also receive the message that the kind of professional misconduct in which Dr. Kliman was found by the Panel to have engaged is unacceptable and cannot be tolerated. It will also serve to protect the public while Dr. Kliman undertakes remediation and it will serve to reinforce public confidence in the profession's ability to self-regulate.

Permanent Restriction from Providing Orthodontic Care

(c) As a strong public protection measure, the Panel ordered that Dr. Kliman be permanently restricted from providing orthodontic treatment to patients.

Coursework Required

(d) During the first six (6) months of his suspension, the Panel ordered that Dr. Kliman take approved courses on informed consent, ethics, and recordkeeping fundamentals. The Panel also ordered that, within the twelve (12)-month period of his

suspension, the Registrant is to take a second course in recordkeeping, namely the College's Applied Recordkeeping course. The requirement that Dr. Kliman take these courses, particularly before he returns to practice at the end of his suspension period, will support him in remediating his practice and it will protect the public from further acts of professional misconduct by him while he upgrades his skills and understanding.

Clinic Supervision: 12 Months

(e) The Panel ordered that upon returning to practice, that Dr. Kliman be supervised and mentored by a Clinical Supervisor for a period of twelve (12) months. Clinical supervision is a more stringent and rigorous requirement than practice monitoring. It requires far more hands-on work by the supervisor with the registrant. This element of the penalty will again support Dr. Kliman in his remediation work and will offer a further element of protection for the public, and specifically, for his patients.

Practice Monitoring: 36 Months

(f) The Panel also ordered that upon being allowed to practice without clinical supervision, that Dr. Kliman shall be subject to Practice Monitoring for a further period of thirty-six (36) months. During this period, the Practice Monitor shall focus their work with Dr. Kliman on informed consent, treatment planning and recordkeeping. Requiring the Registrant to have his practice monitored for an additional period of thirty-six (36) months will further support Dr. Kliman in his remediation work and will continue to offer a further element of protection for the public.

[41] In his submissions, College counsel acknowledged that he was unable to find any caselaw that was directly on point with the facts of this case. He directed the Panel to three cases that each had some similar elements to Dr. Kliman's case (*RCDSO v Segura*, 2023 ONRCDSO 7; *RCDSO v Estrabillo*, 2021 ONRCDSO 6; and *RCDSO v Mascarin*, 2018 ONRCDSO 6). *Segura* involved multiple breaches with respect to one patient and the registrant received a suspension of eight (8) months. *Estrabillo* involved multiple breaches with respect to one patient and the registrant received a suspension of ten (10) months. In *Mascarin,* the case involved multiple breaches with respect to one patient, however the registrant had a discipline history and he was ordered to serve a suspension of eighteen (18) months.

[42] The Panel found that the penalty as a whole was proportionate to the severity of Dr. Kliman's misconduct. It reflects the mitigating and aggravating factors, and the Panel favourably considered Dr. Kliman's willingness to work with the College to agree on a statement of facts and a joint submission on penalty. Nevertheless, the professional misconduct was serious and prolonged, it involved multiple breaches with respect to multiple patients, and it highlighted significant weaknesses in Dr. Kliman's practice. The penalty imposed thus provides for stringent remediation requirements, it provides specific and general deterrence, and it offers significant protection to the public.

[43] Finally, the panel accepted the parties' agreement on costs. An order for costs in the amount of $10,000.00 is in line with costs orders in other one-day uncontested matters that come before this Discipline Committee.

I, Judy Welikovitch, sign these Reasons for Decision as Chairperson of this Discipline Panel.

April 14, 2026

______________________________	______________________________
Judy Welikovitch Chair, Discipline Committee Panel	Date

APPENDIX "A"

RCDSO v. Dr. Kevin Kliman

Dr. Kliman, as you know, this Discipline panel has ordered you be given an oral reprimand as part of the sanction imposed upon you. The reprimand should impress upon you the seriousness of your misconduct.

The fact that you have received this reprimand will be part of the public portion of the Register and, as such, part of your record with the College.

You will be given an opportunity to make a statement at the end of the reprimand if you wish.

The panel has found that you have engaged in multiple acts of professional misconduct. The misconduct related to providing treatment to multiple patients that you knew or ought to have known was beyond your competence, failing to obtain informed consent and failing to maintain several other standards of practice including standards relating to diagnosis, performing the necessary diagnostic work up, creating treatment plans and monitoring, and failing to make and keep appropriate records as required.

The cumulative effect of your conduct would reasonably be regarded by Registrants as disgraceful, dishonourable, unprofessional and unethical.

Your professional misconduct is a matter of profound concern. It is completely unacceptable to your fellow dentists and to the public. You have brought discredit to the entire profession and to yourself. Public confidence in this profession has been put in jeopardy.

Of special concern to us is the fact that the professional misconduct in which you engaged involved multiple patients over an extended period of time and included repeated instances of providing patient care beyond the limits of your competence and failing to recognize when you need to engage a specialist.

We expect that you will learn from this experience to improve your practice and will use the remedial tools imposed by our order to be more aware of the limits of your competency and the heightened risks of engaging in virtual-only dentistry.

As I advised earlier, you will now be given an opportunity to make a comment if you wish to do so. This is **not** an opportunity for you to debate the merits or the correctness of the decisions we have made.

Do you have any questions or do you wish to make any comments?

(*Hear the Registrant's comments at this point)*

Thank you for attending today. We are adjourned.

APPENDICES – NOTICES OF HEARING

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, Mr. Ahmad Mozaffari, in this matter at:

Mr. Ahmad Mozaffari
Steinecke Maciura LeBlanc
401 Bay Street, Suite 2308, P.O. Box 23
Toronto, ON M5H 2Y4
Tel: 416.599.2200
email: amozaffari@sml-law.com

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;

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 2019-2021 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 2019-2021, you provided orthodontic treatment to JM (the Patient).
   - You misdiagnosed the Patient with a Class I occlusion when the Patient likely had a Class III right molar and Class II bilateral cuspid malocclusion with a lingual crossbite on the right second mandibular premolar 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 respond to the Patient's clinical questions about their treatment progress when they uploaded "check-in" photos.
- You provided treatment that did not result in an acceptable outcome for the Patient.
- 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 an ideal treatment outcome would not be achievable and that the proposed treatment would push teeth out of the arch.
- 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 never communicated directly with the Patient even when the Patient requested to speak with you directly, and they decided to stop the treatment and requested a refund because they were unable to speak with you.

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 2019-2021, 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 risked pushing the Patient's teeth out of the arch and having a significant detrimental impact on them.

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 2019-2021, 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 an ideal treatment outcome would not be achievable and that the proposed treatment would push teeth out of the arch.
   - 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 2019-2021, 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 view pictures showing the Patient’s bite;
    - Interdigitated scans;
    - 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, Mr. Ahmad Mozaffari, in this matter at:

Mr. Ahmad Mozaffari
Steinecke Maciura LeBlanc
401 Bay Street, Suite 2308, P.O. Box 23
Toronto, ON M5H 2Y4
Tel: 416.599.2200
email: amozaffari@sml-law.com

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

24-0312

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 flr
Toronto ON M5V 2Y1

NOTICE OF HEARING

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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 2018-2019 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 2018-2019, you provided orthodontic treatment to SC (the Patient).
   - You misdiagnosed the Patient with a Class II malocclusion when they had a complex Class III malocclusion.
   - 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" with you after 90 or 180 days of treatment.
   - You provided treatment that you knew or ought to have known would result in a

larger open bite and negative overjet and would leave the Patient with a non-functional 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 a larger open bite and negative overjet and the impact that these outcomes would have on the Patient.
- 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 before impressions were taken and before the Patient was able to see the images showing their projected results.
- 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.

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 2018-2019, 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.

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

2018-2019, 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 a larger open bite and negative overjet and the impact that these outcomes would have on the Patient.
- 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 before impressions were taken and before the Patient was able to see the images showing their projected results.
- 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 2018-2019, 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 the following:
    - Interdigitated scans that showed the Patient's bite;
    - Diagnostic radiographs;
    - An orthodontic analysis;
    - A problem list;
    - An objective list; or
    - A treatment plan.
- You did not retain a copy of the digital model(s) on which the Patient's treatment was based, and permitted the model(s) to be retained by a third-party company

that revoked your access to records of your own dental treatment.

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, Mr. Ahmad Mozaffari, in this matter at:

Mr. Ahmad Mozaffari
Steinecke Maciura LeBlanc
401 Bay Street, Suite 2308, P.O. Box 23
Toronto, ON M5H 2Y4
Tel: 416.599.2200
email: amozaffari@sml-law.com

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;

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
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Toronto ON M5V 2Y1

NOTICE OF HEARING

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   Particulars:

   - In or about 2019-2020, you provided orthodontic treatment to GG (the Patient).
   - You did not diagnose the Patient's occlusion and or make any diagnostic statement in the Patient's records.
   - 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 review the photographs that the Patient uploaded to SmileDirectClub to “check-in” about their progress and were not aware that the Patient had uploaded the photographs.
- You provided treatment that created a posterior open bite for the Patient and offered refinement treatment to the Patient that you knew or ought to have known would create an anterior 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 a posterior or anterior open bite and the impacts that these outcomes would have on the Patient.
- 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 at all during the treatment, even when the Patient raised clinical concerns about the impact that the treatment was having on their bite. SmileDirectClub staff reviewed the Patient’s bite issues and made recommendations without your involvement.

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.
   <u>Particulars:</u>

   - 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.

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 a posterior or anterior open bite and the impacts that these outcomes would have on the Patient.
   - 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:

    - Interdigitated scans that showed the Patient's bite;
    - Diagnostic radiographs;
    - An orthodontic analysis;
    - A problem list;
    - An objective list; or
    - A treatment plan.
- You did not retain a copy of the digital model(s) on which the Patient's treatment was based, and permitted the model(s) to be retained by a third-party company that revoked your access to records of your own dental treatment.

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, Mr. Ahmad Mozaffari, in this matter at:

Mr. Ahmad Mozaffari
Steinecke Maciura LeBlanc
401 Bay Street, Suite 2308, P.O. Box 23
Toronto, ON M5H 2Y4
Tel: 416.599.2200
email: amozaffari@sml-law.com

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;

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 2018-2020 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 2018-2020, you provided orthodontic treatment to DA (the Patient).
   - Your diagnosis of the Patient was incomplete and did not include relevant complicating factors, including the Patient's peg-shaped tooth, missing incisor, midline discrepancy, crossbite or diastema.
   - You treated the Patient without a clear understanding of the Patient's chief complaint.
   - 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.
- 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 risk that the treatment would worsen the Patient's bite and the impacts that this outcome would have on the Patient.
- 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 at all during the treatment, even when the Patient raised clinical concerns about the fit off their aligners and raised questions about whether a dentist was overseeing their treatment at all. Instead, SmileDirectClub staff repeatedly directed the Patient to re-submit pictures of their teeth.
- You did not clarify with the Patient or ask any follow-up questions about whether the Patient had recently had x-rays with their regular dentist, despite the Patient answering this question inconsistently on two different forms.

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 2018-2020, 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.

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 2018-2020, 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 worsen the Patient's posterior bite and the impacts that these outcomes would have on the Patient.
- 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 2018-2020, 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 bite pictures;
    - Diagnostic radiographs;
    - An orthodontic analysis;
    - A problem list;
    - An objective list; or
    - A treatment plan.
- The pictures of the Patient's teeth in your records are skewed and missing proper angulation.

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, Mr. Ahmad Mozaffari, in this matter at:

Mr. Ahmad Mozaffari
Steinecke Maciura LeBlanc
401 Bay Street, Suite 2308, P.O. Box 23
Toronto, ON M5H 2Y4
Tel: 416.599.2200
email: amozaffari@sml-law.com

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;

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 s.51(1)(c) of the Health Professions Procedural Code of the *Dentistry Act*, *1991*, Statutes of Ontario, 1991, Chapter 24 in that, during the years 2022 and/or 2023, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely DH, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about 2022 and/or 2023, you provided orthodontic treatment to DH (the “Patient”).
   - The diagnosis was incorrect.
   - Your case work-up was incomplete because you did not perform any orthodontic analysis and did not create or provide the Patient with a treatment plan for their orthodontic treatment.
   - You did not discuss any treatment plan with the Patient.

- The Patient was not clinically assessed at 90 days or checked periodically to assess damage to her teeth or supporting structures.
- You did not adequately monitor the Patient's orthodontic progress during the treatment to assess whether detrimental changes were occurring. There was no indication that you monitored the Patient or were aware that the Patient had concerns about her treatment even after she informed Smile Direct Canada about increased tooth mobility. There was no attempt by you to contact the Patient to discuss her concerns.
- 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 recommend that the Patient consult an orthodontist and/or a periodontist to discuss alternative treatment options.
- 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 treatment.
- Your records for the patient were incomplete, and did not include:
    - A problem list, objective list or treatment plan;
    - Side bite views;
    - Scans that were interdigitated and showed the Patient's bite; or
    - X-rays for the Patient.
- You failed to maintain the Patient's records as required.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code of the *Dentistry Act*, *1991*, Statutes of Ontario, 1991, Chapter 24 in that, during the years 2022 and/or 2023, 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 relative to one of your patients, namely DH, contrary to paragraph 5 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about 2022 to 2023, you provided orthodontic treatment to DH (the "Patient").
   - You knew or ought to have known that the Patient was not an appropriate candidate for orthodontic aligner treatment and not an appropriate case to be treated by a general dentist given her periodontal bone loss and very deep bite.
   - You did not understand the potential effects of your treatment on the Patient's bite.
   - You did not refer the Patient to an orthodontist for consultation and/or treatment.

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code of the *Dentistry Act*, *1991*, Statutes of Ontario, 1991, Chapter 24 in that, during the years 2022 and/or 2023, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent relative to one of your patients, namely DH, contrary to paragraph 7 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   <u>Particulars:</u>

   - In or about 2022 to 2023, you provided orthodontic treatment to DH (the "Patient").
   - You failed to obtain the Patient's informed consent to treatment in that:
     - You did not discuss the treatment modalities, risks, benefits and alternatives of the orthodontic treatment with the Patient before beginning the treatment;
     - You did not discuss any treatment plan with the Patient;
     - You did not recommend that the Patient consult an orthodontist and/or a periodontist to discuss alternative treatment options;
     - 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 treatment.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code of the *Dentistry Act, 1991*, Statutes of Ontario, 1991, Chapter 24 in that, during the year 2022 and/or 2023, you failed to keep records as required by the Regulations relative to one of your patients, namely DH, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended and s. 38(b) and/or 38(c) of Regulation 547, Revised Regulations of Ontario, 1990, as amended.

   <u>Particulars:</u>

   - In or about 2022 to 2023, you provided orthodontic treatment to DH (the "Patient").
   - Your records for the Patient were incomplete, and did not include:
     - A problem list, objective list or treatment plan;
     - Side bite views;
     - Scans that were interdigitated and showed the Patient's bite;
     - X-rays for the Patient.
   - You failed to maintain the Patient's records as required.

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, Mr. Ahmad Mozaffari, in this matter at:

Mr. Ahmad Mozaffari
Steinecke Maciura LeBlanc
401 Bay Street, Suite 2308, P.O. Box 23
Toronto, ON M5H 2Y4
Tel: 416.599.2200
email: amozaffari@sml-law.com

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 27th day of June, 2025.

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;

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 s.51(1)(c) of the Health Professions Procedural Code of the *Dentistry Act*, *1991*, Statutes of Ontario, 1991, Chapter 24 in that, during the years 2020 and/or 2021, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely IO, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about 2020 to 2021, you provided orthodontic treatment to IO (the "Patient").
   - The records did not demonstrate that you identified a problem list, objective list or treatment plan.
   - The diagnosis was incorrect.
   - You did not discuss any treatment plan with the Patient
   - The Patient was not clinically assessed at 90 days or checked periodically to assess damage to her teeth or supporting structures.

- You did not adequately monitor the Patient's orthodontic progress during the treatment to assess whether detrimental changes were occurring, including after the Patient raised concerns about treatment.
- 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 recommend that the Patient consult an orthodontist to discuss alternative treatment options.
- You provided treatment you knew or ought to have known would have a detrimental impact on the Patient's bite.
- Your records for the Patient were incomplete, and did not include:
    - A problem list, objective list or treatment plan;
    - Side bite views;
    - X-rays for the patient; or
    - Scans that were interdigitated and showed the Patient's bite.
- You failed to maintain the Patient's records as required.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code of the *Dentistry Act*, *1991*, Statutes of Ontario, 1991, Chapter 24 in that, during the years 2020 and/or 2021, 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 relative to one of your patients, namely IO, contrary to paragraph 5 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

    Particulars:

    - In or about 2020 to 2021, you provided orthodontic treatment to IO (the "Patient").
    - You knew or ought to have known that the Patient was not an appropriate candidate for aligner treatment given her severe underlying skeletal problem; treatment by a specialist and possible orthognathic surgery should have been considered.
    - You did not understand the potential effects of your treatment on the Patient's bite.
    - You did not refer the Patient to an orthodontist for consultation and/or treatment.

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code of the *Dentistry Act*, *1991*, Statutes of Ontario, 1991, Chapter 24 in that, during the years 2020 and/or 2021, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent relative to one of

your patients, namely IO, contrary to paragraph 7 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- In or about 2020 to 2021, you provided orthodontic treatment to IO (the “Patient”).
- You failed to obtain the Patient’s consent to treatment in that:
  - You did not discuss the treatment modalities, including possible orthognathic surgery, risks, benefits and alternatives of the orthodontic treatment with the Patient before beginning the treatment;
  - You did not discuss any treatment plan with the Patient;
  - You did not recommend that the Patient consult an orthodontist to discuss alternative treatment options;
  - 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 treatment.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code of the *Dentistry Act, 1991*, Statutes of Ontario, 1991, Chapter 24 in that, during the year 2020 and/or 2021, you failed to keep records as required by the Regulations relative to one of your patients, namely IO, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended and s. 38(b) and/or 38(c) of Regulation 547, Revised Regulations of Ontario, 1990, as amended.

Particulars:

- In or about 2020 to 2021, you provided orthodontic treatment to IO (the “Patient”).
- Your records for the Patient were incomplete, and did not include:
  - A problem list, objective list, or treatment plan;
  - Side bite views;
  - X-rays for the Patient; or
  - Scans that were interdigitated and showed the Patient’s bite.
- You failed to maintain the Patient’s records as required.

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, Mr. Ahmad Mozaffari, in this matter at:

Mr. Ahmad Mozaffari
Steinecke Maciura LeBlanc

401 Bay Street, Suite 2308, P.O. Box 23
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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 27th day of June, 2025.

Royal College of Dental Surgeons of Ontario