

**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. HISHAM FAROUK KALOTI**, of the City of Norwood, 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. Hisham Farouk Kaloti**  
**4243 Hwy 7 Box #8**  
**Norwood, ON K0L 2V0**

## **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 *Code* in that, during the year(s) 2019 and/or 2020, you contravened a standard of practice or failed to maintain the standards of practice of the profession in relation to your care of the patient, Patient A, contrary to paragraph 1 of Section 2 of Ontario Regulation 853/93 under the *Dentistry Act, 1991*, as amended (“*Professional Misconduct Regulation*”).

#### Particulars:

- You failed to maintain the standard of practice of the profession with respect to your preliminary assessment and diagnosis, treatment planning, obtaining

informed consent, and execution of prosthodontic treatment in respect of Patient A's care:

- You failed to document a diagnosis before forming a treatment plan.
- Your treatment planning was deficient. You failed to address the patient's urgent needs, including extractions, root canal treatment, and cracked, chipped and missing teeth before starting aesthetic restorative work.
- You failed to appropriately obtain the patient's informed consent to treatment, including reviewing the risks of treatment, alternative options, your treatment fees, and the unique personal circumstances of the patient.
- You did not address extensive decay and a periapical abscess on tooth 37 before the preparation of teeth for crowns and veneers.
- You did not remove decay on teeth 46, 37, and 36 prior to the post and core restoration.
- You used fixed dental restorations or prostheses manufactured by a dental technician (Maher Shelleh) who was not licensed to sell medical devices in Canada.
- You did not try-in the crowns and veneers to assess the accuracy of the margins and interproximal surfaces, verify the occlusion, or ensure the patient approved of the aesthetics prior to cementation.
- Your chart notes indicate that crowns were cemented on teeth 34, 35, 36, and 37 when in fact it was a cantilever bridge. You did not mention any change in treatment plan in the patient's records.
- It appears that tooth 45 was cemented as a crown but was planned for a veneer according to a lab prescription. You did not mention any change in the treatment plan in the patient's records.
- You cemented an ill-fitting splinted cantilever prosthesis with open margins on the distal of tooth 36 and the mesial and distal margins of teeth 37 and 25.
- You cemented a veneer with an open margin on tooth 33.
- You cemented a temporary crown on tooth 27.
- You permanently cemented a cantilevered bridge over the decayed root of tooth 34.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the years) 2019 and/or 2020, you treated or attempted to treat Patient A for a disease, disorder or dysfunction of the oral-facial complex that you knew or ought to have known was beyond your expertise or competence, contrary to paragraph 5 of Section 2 of the *Professional Misconduct Regulation*.

Particulars:

- The deficiencies in your assessment, diagnosis, treatment planning, obtaining informed consent, and execution of prosthetic treatment demonstrate a lack of expertise in the area of prosthodontic dentistry such that you ought to have known that providing treatment for Patient A was beyond your competence and referred her care to an appropriate specialist.
3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the year(s) 2019 and/or 2020, you treated Patient A 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, contrary to paragraph 7 of Section 2 of the *Professional Misconduct Regulation*.

Particulars:

- You failed to appropriately obtain Patient A's informed consent to treatment, including reviewing the risks of treatment, alternative options, your treatment fees, and the unique personal circumstances of the patient:
  - You did not obtain the patient's informed consent to retain the root tips of 34 and 38 and the decayed 47 until all the aesthetic restorative work was done.
  - You did not obtain the patient's informed consent to the permanent cementation of a cantilever bridge that covered the root tip of 34.
  - You did not obtain the patient's approval of the prostheses prior to final cementation.
  - You did not obtain a signed informed consent form from the patient with respect to any of the treatment.
  - You failed to review with the patient the fact that your fees for veneer and crown treatment were significantly higher than the recommended

fees for that treatment in the Ontario Dental Association (ODA)  
Suggested Fee Guide for General Practitioners.

- You did not obtain Patient A's consent to use fixed dental restorations or prostheses from Maher Shelleh, a dental technician who was not licensed to sell medical devices in Canada.
4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the year 2020, you misrepresented a remedy, treatment, device or procedure to the patient, Patient A, contrary to paragraph 12 of Section 2 of the *Professional Misconduct Regulation*.

Particulars:

- You did not tell Patient A that you would use fixed dental restorations or prostheses from Maher Shelleh, a dental technician located in Jordan who was not licensed to sell medical devices in Canada.
  - You told Patient A that the prosthesis and/or fixed dental restorations were fabricated by a laboratory in Florida called "Inovia Dental Solutions", which does not exist and/or is not a dental laboratory licensed to sell medical devices in Canada.
5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the year(s) 2019 and/or 2020, you failed to keep records in relation to the patient, Patient A, as required by the regulations, contrary to paragraph 25 of Section 2 of the *Professional Misconduct Regulation*.

Particulars:

- You failed to maintain a complete, clear and accurate record of Patient A's dental care:
  - Your records are missing:
    - A medical systems review, including current medications;
    - Periodontal charting;
    - A diagnosis; and
    - An extra-oral exam.
  - Your records are missing clinical chart notes from a consultation on December 12, 2019.

- You failed to document several obvious diagnostic findings based on diagnostic radiographs dated January 15, 2020, such as:
    - Root tip of tooth 34 under cantilever bridge;
    - Tooth 36 decay;
    - Tooth 48 partially impacted;
    - Tooth 37 decay under existing crown; and
    - Root tips of teeth 28 and 38.
  - You did not make chart entries for teeth 17, 16, 15, 14, 13, 12, 11, 21, 22, 23, 24, 25, 35, 34, 33, 32, 31, 41, 42, 43, 45 or the root tips on 38 and 34 on January 15, 2020, despite billing a complete oral examination, 10 radiographs, and diagnostic photographs.
  - You failed to accurately represent the patient's oral and dental conditions on the odontogram dated June 25, 2020: it does not show the root stumps or decay on teeth 34 and 38.
  - You failed to adequately document your communications with dental laboratories. Your lab prescriptions for fabricating the prostheses are incomplete and contain unclear information about the material to be used for the crowns and veneers.
  - You did not document the specifics of what was discussed during a "smile design" consultation on February 13, 2020.
  - You failed to retain significant portions of the patient's dental record. You asserted that these portions of the dental record were damaged or destroyed in an office flood but did not document any information about which records were destroyed or any of your attempts to salvage, restore, or preserve these records, or to replace any destroyed records after the flood.
6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the year 2020, you signed or issued a certificate, report or similar document in respect of the patient, Patient A, that you knew or ought to have known contained a false, misleading or improper statement, contrary to paragraph 28 of Section 2 of the *Professional Misconduct Regulation*.

Particulars:

- You double-billed tooth 14 for veneers (February 19, 2020).

- You billed for veneers and crowns (February 19, 2020) before the date of their insertion (June 26, 2020).
  - You billed the treatment of teeth 35, 36 and 37 as crowns, when you permanently cemented a bridge connecting 34-35-36-37 (June 26, 2020).
7. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the year(s) 2019 and/or 2020, you charged the patient, Patient A, a fee that is excessive or unreasonable in relation to the service performed, contrary to paragraph 31 of Section 2 of the *Professional Misconduct Regulation*.

Particulars:

- You billed an excessive fee for veneers (code 27602), charging a fee that was more than double the ODA Suggested Fee Guide for general practitioners and that exceeded the speciality fee guide for prosthodontists, without justification in the records or any documentation of the patient's informed consent to the increased fee. You billed a fee for veneers that was higher than that suggested for crowns.
  - You billed an excessive fee for crowns (code 27211), charging a fee that was almost double the ODA's suggested fee for general practitioners and was commensurate with the ODA's suggested fee for prosthodontists, without justification in the records or any documentation of the Patient's informed consent to the increased fee.
8. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the year 2020, you submitted an account or charge for dental services in respect of the patient, Patient A, that you knew or ought to have known was false or misleading, contrary to paragraph 33 of Section 2 of the *Professional Misconduct Regulation*.

Particulars:

- You double-billed tooth 14 for veneers (February 19, 2020).
- You billed for veneers and crowns (February 19, 2020) before the date of their insertion (June 26, 2020).
- You billed the treatment of teeth 35, 36 and 37 as crowns, when you permanently cemented a bridge connecting 34-35-36-37 (June 26, 2020).

9. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the year 2020, you engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical, in relation to the patient, Patient A, contrary to paragraph 59 of Section 2 of the *Professional Misconduct Regulation*.

Particulars:

- You used fixed dental restorations or prostheses manufactured by a dental technician (Maher Shelleh) who was not licensed to sell medical devices in Canada.
- You misled the patient and did not provide accurate information about the dental laboratory that manufactured the prostheses.
- You failed to retain significant portions of the patient's dental record. You told the College that these portions of the dental record were damaged or destroyed in an office flood but did not document any information about which records were destroyed or any of your attempts to salvage, restore, or preserve these records, or to replace any destroyed records after the flood.
- You wrote off \$12,750 from the patient's financial ledger on July 20, 2020, without documenting a reason in the records.

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

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

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

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

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

or any combination thereof.

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

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

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

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

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

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

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

DATED at Toronto, this 22<sup>nd</sup> day of August, 2024.



Royal College of Dental Surgeons of Ontario

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## **NOTICE OF HEARING**

### **ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO**

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