

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, between the years 2017 and 2023, you contravened a standard of practice or failed to maintain the standards of practice of the profession in relation to your care of the patients, Patient G, Patient H, Patient F, Patient D, and/or Patient I, 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 in implant dentistry with respect to your preliminary evaluation and pre-surgical

assessment, treatment planning, obtaining informed consent, execution of surgical treatment, post-surgical follow-up and pre-prosthetic assessment, execution of prosthetic treatment, long-term follow-up and maintenance of implants and/or implant-supported prostheses or restorations, and management of complications:

- You failed to carry out an appropriate pre-implant examination and determine of the complexity level of the proposed implant treatment. (Patient G; Patient H; Patient F; Patient D; Patient I)
- Your treatment plan failed to address severe bone loss apparent in a pre-operative radiograph. (Patient G)
- You failed to create or document a final treatment plan. (Patient H)
- You failed to plan to stabilize the patient's active periodontal disease before and after implant placement. (Patient F)
- You did not use consistent tooth numbering during the different stages of implant treatment, and you did not appropriately determine the final positions of the implants before beginning treatment. (Patient D)
- You failed to have adequate informed consent discussions and appropriately obtain the patient's informed consent to implant treatment, including reviewing the risks of treatment, alternative options, and unique personal circumstances of the patient. (Patient H; Patient F; Patient D; Patient I)
- You used materials that were not licensed as medical devices for sale in Canada, specifically bone graft supplied by GDT Dental Implants (Patient D) and dental implants supplied by DSI Dental Solutions. (Patient G; Patient H; Patient I)
- You used fixed dental restorations or prostheses manufactured by a dental laboratory (Foo Tian Dental Lab) that was not licensed to sell medical devices in Canada. (Patient H; Patient I)
- You did not show a rationale for the sequencing of treatment, where two implants were placed months after the placement of implants on six other teeth and after three intraoral scans for the fabrication of maxillary implant-supported bridges. (Patient I)
- You placed implants without a surgical guide even though the case was complex. (Patient D; Patient I)

- You placed implants without taking intra-operative or immediate post-operative radiographs to check their placement. (Patient G; Patient F)
 - You placed two implants (teeth 26 and 27) such that the apices were positioned in the sinus, and you did not determine the initial mechanical stability of those implants. (Patient I)
 - You failed to verify implant osseointegration before proceeding to the prosthetic stage of treatment. (Patient H; Patient F; Patient D; Patient I)
 - You did not schedule a post-insertion evaluation after the insertion of the definitive prosthesis. (Patient H; Patient F; Patient D; Patient I)
 - You failed to adequately investigate and manage complications such as an implant crown debonding, implant crown mobility, bone loss around implants, and ill-fitting crown margins. (Patient F; Patient D; Patient I)
 - You fabricated a night guard before you prepared a tooth for a crown. (Patient H)
 - You placed defective crown restorations with overhangs and/or defective margins. (Patient H; Patient F)
2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, between the years 2017 and 2023, you treated or attempted to treat Patient G, Patient H, Patient F, Patient D, and/or Patient I 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, work-up, treatment planning, obtaining informed consent, implant placement and prosthetic treatment demonstrate a lack of expertise in the area of implant dentistry such that you ought to have known that providing treatment for Patient G, Patient H, Patient F, Patient D, and/or Patient I was beyond your competence and referred their care to an appropriate specialist(s).
3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, between the years 2017 and 2023, you treated the patients Patient G,

Patient H, Patient F, Patient D, and/or Patient I 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 have adequate informed consent discussions and appropriately obtain the patient's informed consent to implant treatment, including reviewing the risks of treatment, alternative options, and unique personal circumstances of the patient. (Patient H; Patient F; Patient D; Patient I)
 - You did not tell the patient that you would use materials (bone graft supplied by GDT Dental Implants and/ or implants supplied by DSI Dental Solutions) that were not licensed as medical devices for sale in Canada. (Patient G; Patient H; Patient D; Patient I)
 - You did not tell the patient that you would use fixed restorations or prostheses manufactured by a dental laboratory (Foo Tian Dental Lab) that was not licensed to sell medical devices in Canada. (Patient H; Patient I)
4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, between the years 2017 and 2023, you failed to keep records in relation to the patients Patient G, Patient H, Patient F, Patient D, and/or Patient I as required by the regulations, contrary to paragraph 25 of Section 2 of the *Professional Misconduct Regulation*.

Particulars:

- Your records were missing chart entries. (Patient H)
- You documented late chart entries, some of which were made significantly after the date of service. (Patient G; Patient H; Patient F)
- You repeatedly failed to document your findings on examination and your diagnoses. (Patient D)
- You failed to appropriately document your complete oral examination of the patient. (Patient G; Patient H; Patient F)
- You did not document an appropriate informed consent discussion with the patient including a discussion of the risks and benefits of treatment, alternative treatment options, cost and duration of implant treatment, anticipated post-

surgical sequelae, and/or potential complications, before initiating implant treatment. (Patient H; Patient F; Patient D; Patient I)

- You recorded different tooth numbers for implants during the treatment planning, surgical and prosthetic stages of treatment. (Patient D)
 - You did not retain commercial laboratory invoices in the patient's chart. (Patient H; Patient F; Patient D; Patient I)
 - You repeatedly failed to retain your radiographs and/or document your interpretation of radiographs in the patient's chart. (Patient G; Patient H; Patient D; Patient I)
5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, between the years 2017 and 2022, you signed or issued a certificate, report or similar document in respect of the patients Patient G, Patient H, Patient F, and/or Patient I 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 billed for treatment not rendered or services already included in the professional fee:
 - You billed for recementing/rebonding a tooth (code 29102) on November 28, 2022, which was not supported by any chart entry including the late chart entry made on February 10, 2023. (Patient G)
 - You billed for occlusal adjustments (codes 16511 and 16512) on June 29, 2017 and July 24, 2017, which were not supported by the chart entries and/or were inappropriate as this service was already included in the professional fee for a removable prosthesis. (Patient F)
 - You billed for a crown (code 27211) for a missing tooth 25 on November 16, 2021. (Patient H)
 - You billed for complete oral examinations, but the patient charts did not support that such an examination was done. (Patient G; Patient H; Patient F)
- You billed for crowns/dentures and/or commercial laboratory fees before the date of insertion. (Patient H; Patient F; Patient I)

- You used incorrect procedural codes for an intra-oral component, such as a post with bonded composite core, and an implant-supported crown (codes 25764 and 27205), when the records indicated that the component was not inserted or a different component was inserted. You charged fees higher than the suggested fees associated with the correct code. (Patient H; Patient I).
6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, between the years 2017 and 2022, you submitted an account or charge for dental services in respect of the patients Patient G, Patient H, Patient F, and/or Patient I 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 billed for treatment not rendered or services already included in the professional fee:
 - You billed for recementing/rebonding a tooth (code 29102) on November 28, 2022, which was not supported by any chart entry including the late chart entry made on February 10, 2023. (Patient G)
 - You billed for occlusal adjustments (codes 16511 and 16512) on June 29, 2017 and July 24, 2017, which were not supported by the chart entries and/or were inappropriate as this service was already included in the professional fee for a removable prosthesis. (Patient F)
 - You billed for a crown (code 27211) for a missing tooth 25 on November 16, 2021. (Patient H)
 - You billed for complete oral examinations, but the patient charts did not support that such an examination was done. (Patient G; Patient H; Patient F)
- You billed for crowns/dentures and/or commercial laboratory fees before the date of insertion. (Patient H; Patient F; Patient I)
- You used incorrect procedural codes for an intra-oral component, such as a post with bonded composite core, and an implant-supported crown (codes 25764 and 27205), when the records indicated that the component was not inserted or a different component was inserted. You charged fees higher than the suggested fees associated with the correct code. (Patient H; Patient I)

7. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, between the years 2021 and 2023, 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 patients Patient G, Patient H, Patient D, and/or Patient I, contrary to paragraph 59 of Section 2 of the *Professional Misconduct Regulation*.

Particulars:

- You placed a bone graft using materials (xenograft supplied by GDT Dental Implants) that were not licensed as medical devices for sale in Canada. (Patient D)
 - You placed dental implants using materials (implants supplied by DSI Dental Solutions) that were not licensed as medical devices for sale in Canada. (Patient G; Patient H; Patient I)
 - You used fixed dental restorations or prostheses manufactured by a dental laboratory (Foo Tian Dental Lab) that was not licensed to sell medical devices in Canada. (Patient H; Patient I)
 - You did not tell the above-mentioned patients that you were using materials that were not licensed for use in Canada.
8. You are incompetent as provided by s.52(1) of the *Code* in that, between the years 2017 and 2022, your professional care of patients displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that you are unfit to continue to practise or that your practice should be restricted.

Particulars:

- You are incompetent in performing implant dentistry. The deficiencies in your implant treatment showed a lack of knowledge, skill or judgment that demonstrated that you are unfit to continue practising implant dentistry.

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 22nd day of August, 2024.



Royal College of Dental Surgeons of Ontario

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

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