25-0090

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. SOLOMON DAVID WEISS**, 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. SOLOMON DAVID WEISS
2-25 Bellair Street
Toronto ON M5R 3L3

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 years 2019 to 2022, you contravened a standard of practice or failed to maintain the standards of practice of the profession, in relation to the care you provided to LM and/or to AM, contrary to paragraph 1 of Section 2 of Ontario Regulation 853/93 under the *Dentistry Act, 1991*, as amended ("*Professional Misconduct Regulation*").

Particulars:

With respect to LM:

- You failed to maintain the standard of the profession with respect to your diagnosis, work-up, treatment planning, and management of the patient's prosthodontic treatment.
  - You did not complete appropriate clinical investigations into LM's pre-existing dental condition, including her periodontal health, post-accident temporomandibular jaw disorder and recurrent caries, before proceeding with implant-supported crowns on teeth 11 (upper right central incisor) and 22 (upper left lateral incisor) and a crown on tooth 21 (upper left central incisor).
  - You took insufficient photographs and you did not make appropriate models and/or diagnostic wax-ups.
  - You did not evaluate LM's occlusion and habits, and you did not consider the functional aspects of your treatment.
  - You did not appropriately investigate the reason(s) for LM's repeated broken temporary crowns.
- You failed to maintain the standard of the profession in your informed consent practice.
  - You did not appropriately review the risks of treatment and LM's particular risks given her individual circumstances, including poor periodontal health, heavy occlusion, poor oral hygiene and smoking.
  - You did not appropriately review LM's aesthetic expectations and her understanding about the importance of regular dental follow-up.
- You took excessive time to complete the prosthodontic treatment for LM.
- You failed to appropriately refer LM to a specialist.

- You failed to maintain the standard of the profession in your dental recordkeeping practice.
  - You failed to document your clinical findings, interpretations of radiographs and diagnoses.
  - You failed to adequately document your informed consent and other treatment discussions with LM.
  - You failed to document adequate instructions to the laboratory for the fabrication of LM's crowns.
  - Your clinical notes are poorly organized, incomplete and lack sufficient detail.

With respect to AM:

- You failed to maintain the standard of the profession with respect to your diagnosis, work-up, treatment planning, and management of the patient's prosthodontic treatment.
  - You did not complete appropriate clinical investigations into AM's pre-existing dental condition, including his periodontal health and occlusion, before recommending and proceeding with all on 4 dentures.
  - You did not adequately explore AM's pre-treatment concerns and expectations.
  - You did not consider alternate treatment options that could have saved some or all of AM's natural teeth.
  - You embarked on overly aggressive treatment for a relatively young patient. You did not educate and encourage AM to improve his oral hygiene and periodontal health so he might keep some or all of his teeth.
  - You did not evaluate AM's occlusion and habits, and you did not consider the functional aspects of your treatment. You prioritized the patient's aesthetic concerns over functional concerns.
- You failed to maintain the standard of the profession in your informed consent practice.

    - You only gave AM the option of full mouth clearance with implant-supported dentures. You did not offer any alternate treatment proposals, including an option to preserve some or all of his teeth.
    - You did not appropriately review the risks of treatment and AM's particular risks given his individual circumstances, including bone loss, poor periodontal health, smoking and poor oral hygiene.
    - You did not appropriately review AM's aesthetic expectations and his understanding about the importance of regular dental follow-up.
- You took excessive time to complete the prosthodontic treatment for AM.
- You failed to appropriately refer AM to a specialist.
- You failed to maintain the standard of the profession in your dental recordkeeping practice.
    - You failed to document your clinical findings, interpretations of radiographs and diagnoses.
    - You failed to adequately document your informed consent and other treatment discussions with AM.
    - You failed to document adequate instructions to the laboratory for the fabrication of AM's dentures.
    - Your clinical notes are poorly organized, incomplete and lack sufficient detail.

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 2021, you treated or attempted to treat AM 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*.

<u>Particulars:</u>

- You failed to recognize that the complexity of AM's case, including occlusal, functional and aesthetic considerations, was beyond your expertise or competence.
- You failed to appropriately refer the patient to a 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 years 2019 to 2022, you treated LM and/or AM 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*.

<u>Particulars:</u>

With respect to LM:

- You failed to adequately discuss with LM the available treatment options and their respective risks and benefits.
  - You did not appropriately review the risks of treatment and LM's particular risks given her individual circumstances, including poor periodontal health, heavy occlusion, poor oral hygiene and smoking.
  - You did not appropriately review LM's aesthetic expectations and her understanding about the importance of regular dental follow-up.

With respect to AM:

- You failed to adequately discuss with AM the available treatment options and their respective risks and benefits.
  - You only gave AM the option of full mouth clearance with implant-supported dentures. You did not offer any alternate treatment proposals, including an option to preserve some or all of his teeth.

- You did not appropriately review the risks of treatment and AM's particular risks given his individual circumstances, including bone loss, poor periodontal health, smoking and poor oral hygiene.
- You did not appropriately review AM's aesthetic expectations and his understanding about the importance of regular dental follow-up.

4. 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 to 2022, you failed to keep records as required by the regulations, in relation to LM and/or AM, contrary to paragraph 25 of Section 2 of the *Professional Misconduct Regulation* and section 38 of Regulation 547, R.R.O. 1990, under the *Drug and Pharmacies Regulation Act*, as amended.

Particulars:

- You failed to document your clinical findings, interpretations of radiographs and diagnoses.
- You failed to adequately document your informed consent and other treatment discussions with the patients.
- You failed to document adequate instructions to the laboratory for the fabrication of LM's crowns and/or AM's dentures.
- Your clinical notes are poorly organized, incomplete and lack sufficient detail.

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, , in this matter at:

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 5th day of February, 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. SOLOMON DAVID WEISS,** of the City of Toronto, in the Province of Ontario;

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