21-1093

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 **MR. STAN SUNCHUL PARK,** of the City of Mississauga, 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, Chapter 27; 1994, Chapter 27.

TO: **MR. STAN SUNCHUL PARK**
1077 North Service Road #27
Mississauga, ON L4Y 1A6

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, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statues of Ontario, 1991, Chapter 18 in that, during the years 2001 to 2019, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely G.F., contrary to paragraph 1 of the Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

WITH RESPECT TO THE PATIENT'S TOOTH 26:

You recommended, planned and performed inappropriate treatment for the patient's tooth 26 on or around July 16, 2007, specifically the amputation of the buccal root, without considering or taking other non-invasive or minimally invasive steps. Given your diagnosis of an infection and your inadequate investigation into the issue, this treatment was inappropriate.

- You recommended, planned and performed inappropriate treatment for the patient's tooth 26 on or around October 11, 2017, specifically the amputation of a second root, without considering or taking other non-invasive or minimally invasive steps. Given your diagnosis of an infection and your inadequate investigation into the issue, as well as the tooth's poor prognosis with one less root, this treatment was inappropriate.

- You did not replace the crown on the patient's tooth 26 when you performed the root amputation procedure in 2007; this was inappropriate as it led to the development of a "food trap" under the pre-existing crown, which worsened the periodontal issues and predisposed the remaining root to caries.

- You failed to recognize the poor prognosis, and recommended and planned inappropriate treatment, for the patient's tooth 26 on or around December 16, 2013 when probing revealed a 6mm periodontal pocket at one or more sites for this tooth. Given the deep periodontal pocket and the overall poor prognosis of this tooth due to its insufficient bone structure, it was inappropriate that you merely recommended that the patient return in four months for follow-up. You should have recommended periodontal surgery or referred the patient to a specialist.

- You failed to recognize the poor prognosis, and recommended and planned inappropriate treatment, for the patient's tooth 26 on or around May 19, 2015 when you found recurrent caries under the crown that had come off, and recommended placing another crown on this tooth. You performed this inappropriate treatment on or around October 20, 2015. This treatment was inappropriate given the tooth's insufficient tooth structure and the fact that it only had one remaining root, and given the patient's poor periodontal health and significant bone loss.

- You placed a crown on the patient's tooth 26 on or around October 20, 2015 that was inappropriately large and overcontoured, and/or that was poorly fabricated to sit on inadequate tooth structure that was missing at least one root.

- You recommended, planned and performed inappropriate treatment for the patient's tooth 26 on or around September 16, 2018, specifically the recementation of the crown on this tooth. This treatment was inappropriate given the tooth's insufficient tooth structure and the fact that it only had one remaining root, and given the patient's poor periodontal health and significant bone loss.

WITH RESPECT TO THE PATIENT'S TOOTH 36:

- You placed a crown on the patient's tooth 36 on or around December 5, 2001 that was undercontoured and had poor margins finished on restorative material rather than natural tooth structure.

- You failed to recognize the poor prognosis, and recommended and planned inappropriate treatment, for the patient's tooth 36 on or around August 25, 2011 when you recommended placing another crown on this tooth. You performed this inappropriate treatment on or around October 5, 2011. This treatment was inappropriate given the minimal remaining natural tooth structure and the large periapical mesial root lesion that was spreading into the furcation, as observed in radiographs taken August 25, 2011.

- You failed to recognize the poor prognosis, and recommended and planned inappropriate treatment, for the patient's tooth 36 on or around December 16, 2013 when probing measured a 6mm periodontal pocket at the distal of this tooth. Given the deep periodontal pocket and the overall poor prognosis of this tooth due to its periodontal involvement and insufficient natural tooth structure, it was inappropriate that you merely recommended that the patient return in four months for follow-up. You should have recommended periodontal surgery or referred the patient to a specialist.

- You failed to diagnose the serious issues with the patient's tooth 36 on or around September 29, 2015 despite taking a radiograph that showed the furcation involvement and lack of continuity of tooth structure beneath the crown. You made no note of this tooth in your chart notes from this appointment.

- You failed to diagnose the serious issues with the patient's tooth 36 on or around July 11, 2016 despite taking a radiograph that showed the significant bone loss in the furcation region of the tooth. You made no note of this tooth in your chart notes from this appointment.

- You failed to recognize the poor prognosis, and recommended and planned inappropriate treatment, for the patient's tooth 36 on or around May 2, 2017 when you recommended periodontal surgery. You performed crown and caries removal, and recementation of the crown, for this tooth on or around May 8, 2017. Both the treatment recommended and the treatment performed were inadequate given the complete separation of the tooth's roots in the furcation region.

- You failed to recognize the poor prognosis, and recommended and planned inappropriate treatment, for the patient's tooth 36 on or around May 30, 2017 when you recommended placing another crown on this tooth. This treatment was inappropriate given the missing coronal tooth structure, complete separation of the roots in the furcation region, and significant periodontal issues. You also failed to establish a proper diagnosis of this tooth.

- You poorly executed the crown placement on the patient's tooth 36 on or around June 13, 2017, which was also the inappropriate course of treatment. You left an inadequate amount of gutta percha filling at the apex of the distal root, and as such, the crown was not adequately sealed.

- You failed to recognize the poor prognosis, and recommended and planned inappropriate treatment, for the patient's tooth 36 on or around March 6, 2018 when you recommended periodontal surgery. You performed this inappropriate treatment on or around April 16, 2018. This treatment was inappropriate as it was not needed at the time given the poor condition of the tooth, the extent of bone loss and the recurrent caries on the distal root, as observed in radiographs taken April 16, 2018.

- You failed to diagnose the serious issues with the patient's tooth 36 in or around March 2019 despite taking radiographs. You made no note of this tooth in your chart notes from this appointment.

WITH RESPECT TO THE PATIENT'S TEETH 26 AND 36:

- You performed various treatments on teeth 26 and 36, including root amputation, crown placement and periodontal surgery, from the years 2007 through 2018 without properly discussing with the patient about the poor prognosis for each tooth and that, as a result, the treatments were inappropriate.

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 solicitor for the College, [redacted], in this matter at:

[redacted]

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

DATED at Toronto, this 16th day of December, 2021.

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 **MR. STAN SUNCHUL PARK,** of the City of Mississauga, in the Province of Ontario;

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AND IN THE MATTER OF the *Statutory Powers Procedure Act*, Revised Statutes of Ontario, 1990, Chapter S.22, as amended; 1993, Chapter 27; 1994, Chapter 27.

N O T I C E OF H E A R I N G

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