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.

NOTICE OF PUBLICATION BAN

This is formal notice that on October 11, 2022, the panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario made an Order directing that no person shall publish or broadcast the identity of any patients of the Member, 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.

This Order is made pursuant to subsection 45(3) of the *Code*.

Subsection 93(1) of the *Code* reads:

93(1) Every person who contravenes an order made under subsection 7(3) or Section 45 or 47, or who contravenes subsection 76(3), 82(2) or (3), 85.2(1), 85.5(1) or (2) or 85.14(2) or Section 92.1 is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than $50,000 for a first office and not more than $200,000 for a second or subsequent offence.

Dr. Richard Hunter, Chair
Discipline Panel

October 11, 2022
Date

21-1093

THE DISCIPLINE COMMITTEE OF THE 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. 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.

Members in Attendance: Dr. Richard Hunter, Chair
Dr. Elliott Gnidec
Mr. Brian Smith

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	
	)	Luisa Ritacca,
	)	Independent Counsel for the
	)	Discipline Committee of the
	)	Royal College of Dental
	)	Surgeons of Ontario

- and -	)	
	)	Jill Dougherty and
	)	Alyssa Armstrong
	)	For the Royal College of Dental
	)	Surgeons of Ontario
	)	
MR. STAN SUNCHUL PARK	)	Self-Represented

Hearing held by way of videoconference

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on October 11, 2022. This matter was heard electronically.

OVERVIEW

Mr. Park is a former member of the College. In a decision of dated April 12, 2021, Mr. Park was found to be ungovernable by a panel of the Discipline Committee. As a result, his certificate of registration was revoked. That decision was upheld on appeal (see 2021 ONSC 8088).

The allegations before this Panel relate to Mr. Park's treatment and care of one patient, G.F. over the course of almost ten years. As set out in more detail below, Mr. Park's treatment fell below the standard of practice of the profession and resulted in harm for G.F.

THE ALLEGATIONS

The allegation against the Member is as set out in the Notice of Hearing, dated December 16, 2021 (Exhibit 1):

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 a 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 3, 2007, 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 re-cementation 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.

THE MEMBER'S PLEA

As is the usual course, at the outset of the hearing, Mr. Park was asked whether he admitted or denied the allegation set out in the Notice of Hearing. Despite having entered into an agreement with the College and despite signing the Agreed Statement of Facts, wherein he admitted to the allegation of professional misconduct, Mr. Park refused to admit the allegation orally.

In the circumstances, on the advice of Independent Legal Counsel, the Panel asked the College to proceed with its presentation of the Agreed Statement of Facts, which Mr. Park did not oppose. Upon receiving the Agreed Statement of Facts,

the Panel was satisfied that Mr. Park made admissions of professional misconduct in that document, he had the opportunity to obtain independent legal advice before making those admissions, and that he made his admissions on an informed and voluntary basis.

THE EVIDENCE

As is set out above, the College introduced into evidence an Agreed Statement of Facts (Exhibit 2) which substantiated the allegation. The Agreed Statement of Facts (ASF) provides as follows:

> **Allegations of Professional Misconduct**
>
> **Background**
>
> 1. Dr. Stan Sunchul Park (the "Member") received his dental degree from the University of Toronto in 1988. He was registered with the Royal College of Dental Surgeons of Ontario (the "College") as a General Dentist from January 26, 1989 to April 12, 2021.
> 2. The allegations in this matter arise from a complaint from a patient, G.F., dated November 1, 2019, and filed with the College on November 5, 2019 (the "Complaint"). The allegations are set out in the Notice of Hearing dated December 16, 2021 ("Notice of Hearing", attached as Schedule "A").
> 3. At all times relevant to the allegations, the Member was a registered General Dentist with the College and practised dentistry at a clinic that he owned and operated.
>
> **FACTS**
>
> 4. The substance of the Complaint relates to the placement of crowns by the Member on two of G.F.'s teeth when the teeth in question had insufficient root structures to support crowns. G.F. stated that after the Member placed a crown on one of G.F.'s teeth in 2019, the crown was loose such that it "move[d] up and down like a diving board" and that he was unable to bite down on the left side. When G.F. advised the Member of the problem, the Member reassured G.F. but took no further steps to address his concerns. G.F. subsequently received treatment from another dentist, Dr. J.L., who advised G.F. of the problems relating to the teeth in question and provided G.F. with digital images of them.
> 5. During the course of its investigation, the College obtained G.F.'s dental records from the Member and Dr. J.L.. The College's

investigation revealed very serious concerns about the Member's treatment of G.F., and in particular, the Member's treatment of G.F.'s teeth 26 and 36, as detailed below.

The Member's Treatment of G.F.'s Tooth 26

6. In 2004, the Member performed root canal treatment on G.F.'s tooth 26 and, in 2005, placed a crown on that tooth. Between July 2007 and September 2018, the Member provided the following further treatment with respect to G.F.'s tooth 26:

   (a) On or around June 28, 2007, the Member prescribed antibiotics to G.F. to treat a recurrent infection with respect to the root of tooth 26.

   (b) On or around July 16, 2007, the Member saw G.F. and performed an amputation of the buccal root on tooth 26, without exploring other less invasive steps to treat the infection.

   (c) The Member did not replace the pre-existing crown on G.F.'s tooth 26 at the time of the root amputation. The Member's failure to do so resulted in the development of a "food trap" under the crown, worsening G.F.'s periodontal issues and predisposing the remaining root to caries.

   (d) On or around October 3, 2007, G.F. returned to the Member's office with discomfort relating to tooth 26. The Member diagnosed an infection in the root tip and, on or around October 11, 2007, amputated that second root of tooth 26, without exploring other less invasive means of treating the infection. Again, the Member left the pre-existing crown in place.

   (e) The Member saw G.F. again on or around December 16, 2013. During that appointment, probing revealed a 6 mm periodontal pocket at multiple sites on tooth 26. However, the Member simply recommended that G.F. return for follow-up in four months. The Member acknowledges that, at that point, he should have recommended periodontal surgery or referred G.F. to a specialist with respect to tooth 26.

   (f) On or around May 19, 2015, the Member saw G.F. again, at which time the crown on G.F.'s tooth 26 had come off. The Member examined the tooth, found recurrent caries under G.F.'s pre-existing crown and recommended placing another crown on this tooth.

   (g) Radiographs taken on September 29, 2015, prior to crown

replacement on tooth 26, revealed a large periodontal pocket, significant bone loss and insufficient coronal tooth structure to support a crown, in addition to the missing root.

(h) Nonetheless, on October 20, 2015, the Member placed another crown on G.F.'s tooth 26. In addition to the underlying tooth structure and root being insufficient to support a crown, the crown placed by the Member was inappropriately large, overcontoured and/or poorly fabricated to sit on that tooth structure.

(i) In 2018, the new crown came off due to recurrent caries. On or around September 16, 2018, the Member re-cemented the crown on G.F.'s tooth 26 despite the tooth's insufficient tooth structure, its insufficient roots, the patient's poor periodontal health and significant bone loss.

(j) After the crown was re-cemented in 2018, G.F. returned to the Member's office complaining of up-and-down movement of the crown on tooth 26.

(k) The Member acknowledges that tooth 26 was not a candidate for a stand-alone crown, and the Member should not have placed another crown on tooth 26 in October of 2015, nor should he have re-cemented the crown in September 2018.

The Member's Treatment of G.F.'s Tooth 36

7. From in or around 2001 to in or around March 2019, the Member provided the following treatment with respect to G.F.'s tooth 36:

(a) The Member first assessed G.F.'s tooth 36 on or around June 14, 2001, when G.F. complained of a chipped tooth on his bottom left side.

(b) On or around December 5, 2001, the Member placed a crown on G.F.'s tooth 36. That crown was undercontoured and had poor margins finished on restorative material rather than natural tooth structure.

(c) On or around August 25, 2011, G.F. came to see the Member, complaining of discomfort in the area of tooth 36. Radiographs taken of tooth 36 at that time showed minimal remaining tooth structure and a large periapical mesial root lesion that was spreading into the furcation (the place where the roots of the tooth separate). Nonetheless, the Member recommended placing another crown on tooth 36, not recognizing the poor prognosis for this tooth. The Member placed the new crown on

or around October 5, 2011.

(d) The Member also provided inappropriate treatment on or around December 16, 2013, when probing revealed a 6mm periodontal pocket at the distal of tooth 36. The Member recommended that G.F. return for follow-up in four months. The Member acknowledges that, at that time, he should have recommended periodontal surgery or referred the patient to a specialist with respect to tooth 36.

(e) A radiograph taken on March 4, 2014 (prior to re-cementing the crown after endodontic treatment on tooth 36) indicated that G.F. had a completely inadequate amount of tooth structure to support a crown and that the two roots of this tooth appeared separated. Nonetheless, the Member re-cemented the crown on G.F.'s tooth 26 on the same day.

(f) On or around September 29, 2015, the Member took a radiograph that showed the furcation involvement and lack of continuity of tooth structure beneath the crown on tooth 36, but made no note of this in the chart notes for this appointment.

(g) On or around July 11, 2016, the Member took another radiograph of tooth 36 that showed significant bone loss in the furcation region of the tooth. Despite that radiograph, the Member failed to diagnose serious issues with the patient's tooth 36 and again made no note of this tooth in his chart notes from the appointment.

(h) On or around May 2, 2017, at a hygiene appointment, G.F. complained of discomfort in the lower left quadrant of his mouth. The Member removed the crown, performed caries removal and then re-cemented the crown on or around May 8, 2017. The Member also recommended periodontal surgery to try to close or seal the furcation area, which surgery was then postponed. The Member acknowledges that both the recommended treatment and the treatment performed were inadequate given the complete separation of the tooth's roots in the furcation region.

(i) On or around May 30, 2017, the Member recommended placing another crown on tooth 36, notwithstanding the many problems with this course of treatment, including the missing coronal tooth structure, complete separation of the roots in the furcation region, and significant periodontal issues.

(j) On or around June 13, 2017, the Member placed a new crown

on G.F.'s tooth 36. In doing so, the Member left an inadequate amount of gutta percha filling (purified, coagulated latex) at the apex of the distal root, and as such, the crown was inadequately sealed.

(k) On or around March 6, 2018, G.F. complained of a broken tooth on the lower left side. On examination, the Member determined that tooth 36 had fractured with furcation involvement. The Member recommended and planned periodontal surgery for the patient's tooth 36.

(l) The Member performed periodontal surgery on tooth 36 on or around April 16, 2018. At the time, this treatment was inappropriate given the extent of bone loss and recurrent caries on the distal root as observed in the radiographs taken April 16, 2018.

(m) On or around March 2019, the Member failed to diagnose serious issues with respect to G.F.'s tooth 36 despite taking radiographs. The Member also did not make note of this tooth in the chart notes from this appointment.

Failure to Obtain Consent from G.F. and Record-Keeping Issues

8. The College investigation found, and the Member acknowledges, that he did not obtain informed consent from G.F. with respect to the treatment for teeth 26 and 36. G.F. was not informed that the treatment was inappropriate, and he was not informed of the risks, benefits and alternatives to treatment, including the option of no treatment. Additionally, the Member acknowledges that he did not have proper discussions with G.F. about the prognosis of both teeth. In his response to the College investigation dated December 19, 2019, the Member noted that a consent form for the new crown for G.F.'s tooth 26 "was overlooked."

9. The College investigation also revealed and the Member acknowledges that the Member's record-keeping was missing information in respect of informed consent discussions with G.F.

G.F.'s Treatment by Dr. Lott

10. In or around August 2019, G.F. received dental treatment from another dentist, Dr. J.L.. At an appointment in or around October 2019, Dr. J.L. advised G.F. that the crown placed on tooth 26 would fail due to insufficient root structure. During the same appointment, Dr. J.L. also advised G.F. that tooth 36 had minimal root connections and that this tooth would also fail. Dr. J.L. advised that teeth 26 and 36 could be replaced by implants.

The Member's Responses

11. The Member responded to the Complaint by letter dated December 19, 2019 ("**Member's 2019 Response**"). The Member indicated that G.F. had been a patient of the Member's clinic since 1996 and that G.F. experienced a high incidence of caries despite the Member's advice regarding dental hygiene and the patient's best efforts in this regard. The Member stated that G.F. had always been well informed about his dental conditions and treatment options and that treatment was provided with G.F.'s consent.
12. The Member's 2019 Response also acknowledged G.F.'s complaints with respect to teeth 26 and 36, detailed the Member's treatment of those teeth, and ultimately suggested that G.F. was consistently made aware of his high incidence of caries and the need for strict oral hygiene to prevent further decay. In the Member's view, the longevity of G.F.'s crowns was compromised by the recurrent caries.
13. Subsequently, by email and letter dated August 10, 2021, the Member was provided with a copy of the Record of Investigation and an opportunity to provide further comments in writing. The Member gave no further response.
14. The Complaint and Record of Investigation were considered by a Panel of the Inquiries, Complaints and Reports Committee ("ICRC") on October 12, 2021, at which time the Panel expressed concerns and formed the intention to refer specified allegations of misconduct to the Discipline Committee.
15. The Panel indicated the following concerns with respect to the Member's treatment of G.F.'s tooth 26:

    (a) The Member did not properly determine the tooth's limited prognosis and did not develop an appropriate treatment plan for tooth 26;

    (b) Radiographs taken on September 29, 2015 indicated a large periodontal pocket, significant bone loss and insufficient coronal tooth structure to support a crown, in addition to a missing root. Based on these factors, this tooth was not a candidate for a stand-alone crown and the Member should not have placed another crown in October 2015, nor should he have re-cemented the crown in September 2018;

    (c) The Member nonetheless inserted a large bulky crown on top of insufficient tooth structure. The quality of the crown treatment performed by the Member was below acceptable standards and should not have been performed at all.

16. The Panel indicated the following concerns with respect to the Member's treatment of G.F.'s tooth 36:

    (a) The Member did not properly determine the tooth's guarded-to-hopeless prognosis and did not develop an appropriate treatment plan for this tooth, despite multiple instances of significant recurring decay under the crown from 2011 onwards;

    (b) Radiographs taken on March 4, 2014 indicated a completely inadequate amount of tooth structure to support a crown and that the two roots of this tooth appeared to be separated. Based on these observations, the Member should not have re-cemented the crown on this remaining tooth structure on March 4, 2014, nor should he have inserted a second replacement crown in June 2017. It also appeared to the Panel that the Member had unnecessarily recommended and performed periodontal surgery in April 2018.

17. The Panel further indicated concerns that the Member had failed to obtain informed consent from G.F. with respect to treatment for teeth 26 and 36, and that information with respect to the Member's informed consent discussions with G.F. was missing from the Member's clinical records.

18. The College conveyed the concerns identified by the ICRC to the Member by email dated October 29, 2021, and he was given a further opportunity to make written submissions. The Member, by his legal counsel, declined to do so, indicating that his Certificate had been revoked and that he was not able to attend the office to speak to his employees or review his records or x-rays. However, the Member acknowledges that copies of all the records and x-rays with respect to G.F.'s teeth 26 and 36 were included in the Record of Investigation provided to the Member by the College.

19. If this matter had proceeded by way of a contested hearing, the Member would have testified that:

    a. G.F.'s teeth had a high caries rate and were extensively restored;

    b. the work recommended, planned and performed by the Member on tooth 26 and tooth 36 was intended to preserve those teeth for as long as possible and to avoid the need for extraction; and

    c. the problems that were encountered with the crowns placed by the Member on teeth 26 and 36 largely arose from significant

caries (decay) affecting those teeth.

d. Nevertheless, the Member acknowledges that the work recommended, planned and performed by him in relation to tooth 26 and tooth 36 was inappropriate given the poor prognosis of those teeth, and did not meet the standard of practice of the profession.

20. If this matter had proceeded by way of a contested hearing, the Member would have further testified that it was his usual practice to have his patients sign consent forms for all treatments involving crowns, extractions, and surgeries, although the Member acknowledges that he cannot locate consent forms relating to the treatment performed on G.F.'s tooth 26 and tooth 36, which the Member states were lost or misplaced. However, the Member admits that he failed to properly document any informed consent discussions with G.F. in relation to that work, contrary to the standards of practice of the profession.

THE NOTICE OF HEARING

21. By decision dated December 9, 2021, the ICRC referred allegations of professional misconduct against the Member to the Discipline Committee, as set out in the Notice of Hearing.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

22. In view of the foregoing, the Member makes the following admissions of professional misconduct. The Member admits that he committed professional misconduct as alleged in paragraph 1 of the Notice of Hearing.

ACKNOWLEDGEMENT

23. The Member understands the nature of the allegations that have been made against him and that by voluntarily admitting these facts, he waives his right to require the College to otherwise prove these facts.
24. The Member understands that the Panel of the Discipline Committee can accept that the facts herein constitute professional misconduct, and in particular can accept his admissions that they constitute professional misconduct.
25. The Member understands that the Panel of the Discipline Committee can make orders as a result of a finding of professional misconduct, as described in Notice of Hearing.
26. The Member understands that if the Panel makes a finding of professional misconduct, then the Panel's decision and its reasons, or a summary of its reasons, including the facts contained herein, and

the Member's name will be published in the College's annual report, and may be published in the College's register, on its website, and its official publication.

27. The Member understands that the results of this discipline proceeding may be relied upon by the College in any application by the Member to the College for a Certificate of Registration.
28. The Member acknowledges that he has had the opportunity to receive independent legal advice and was encouraged to do so by the College. He further acknowledges that he is entering into this Agreed Statement of Facts freely and voluntarily, without compulsion or duress, and after having had ample opportunity to consult with legal counsel if he so wished.
29. The Member irrevocably acknowledges and agrees that all the facts in this Agreed Statement of Fact are true and accurate.

DECISION AND REASONS FOR DECISION

The Panel finds that Mr. Park engaged in professional misconduct as set out in the Notice of Hearing and Agreed Statement of Facts.

Although no oral admission was obtained, the Panel accepted that Mr. Park had read and confirmed the facts contained within the ASF and voluntarily signed it. Mr. Park denied reading the ASF closely, but College counsel produced evidence that Mr. Park had communicated with counsel to negotiate several points in the ASF before it was finalized. The Panel was satisfied that the evidence contained in the ASF, which Mr. Park admitted, clearly substantiates the allegation of professional misconduct set out in the Notice of Hearing.

The evidence clearly established that Mr. Park failed to maintain the standards of practice of the profession relative to his patient, G.F. G.F. was treated by Mr. Park over an extended period of years. The evidence showed that on numerous occasions, Mr. Park failed to meet the standard of practice in respect of his treatment, diagnosis and documentation as it related to G.F.'s care. Mr. Park failed to recognize the consequences of providing such inappropriate treatment and failed to discuss treatment options with his patient. As a result of Mr. Park's failures, G.F. had to seek treatment from another dentist.

PENALTY SUBMISSIONS

The parties presented the Panel with a Joint Submission on Penalty (Exhibit 3), which provides as follows.

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

   (a) requiring Mr. Park 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; and
   (b) that Mr. Park pay costs to the College in the amount of $5,000.00 in respect of this discipline hearing, such costs to be paid in full on the date that this Order becomes final.

2. The College and Mr. Park 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 of Mr. Park included.

PENALTY DECISION

In keeping with the parties' joint proposal, the Panel orders as follows:

(a) Mr. Park is required 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; and

(b) Mr. Park pay costs to the College in the amount of $5,000.00 in respect of this discipline hearing, such costs to be paid in full on the date that this Order becomes final.

REASONS FOR PENALTY DECISION

The Panel concluded that the proposed Joint Submission on Penalty is appropriate in all the circumstances of this case. The Panel is aware that joint submissions should be respected unless they fall so far outside the range of an

appropriate sanction they would bring the administration of justice into disrepute or are otherwise contrary to public interest.

When considering the appropriateness of the proposed penalty, the Panel was aware that Mr. Park's certificate of registration had already been revoked and as a result, no longer posed a threat to the public.

The reprimand ordered serves to express the Panel's disapproval and disappointment with the treatment Mr. Park provided his patient and sends a clear message to the profession that misconduct of this nature is unacceptable. The Panel found the College's cost request of $5,000 to be appropriate in the circumstances.

At the conclusion of the hearing, Mr. Park indicated that he was prepared to receive his reprimand immediately, and so the Panel delivered its reprimand in the form attached hereto as Schedule "A".

I, Dr. Richard Hunter, sign these Reasons for Decision as Chairperson of this Discipline Panel.

October 18, 2022

Date

SCHEDULE "A"

RCDSO v. Dr. Stan Park

Dr. Park, 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.

The panel has found that you have engaged in professional misconduct in that you contravened a standard of practice of the profession relative to your treatment of patient, G.F.. In particular, you recommended, planned, and performed inappropriate treatment of G.F.'s tooth 26 and 36. You did so, without obtaining proper informed consent and without properly documenting your treatment or recommendations in your patient's medical records.

Of special concern to us is the fact that your treatment in this case resulted in actual patient harm. Based on the facts before us, we understand that the patient had difficulty with the two teeth at issue for several years, which ultimately required him to find care elsewhere.

We recognize that you are a former member of this College, having had your certificate to practice revoked following an earlier case and that as such you do not pose an immediate threat to the public. That said, it is important for you, other members of the College, and the public to understand that the care you provided G.F. was below the standard of care and done so without appropriate informed consent.

Mr. Park, thank you for participating today and providing us with your submissions. We are adjourned.