H180011
H190010
H200002
H200010

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. SUNCHUL STAN 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 January 13, 2021, 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.

January 13, 2021

Dr. Richard Hunter, Chair
Discipline Panel

Date

SD: 1053882

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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. Carol Janik
Mr. Rod Stableforth

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
	)	
DR. STAN SUNCHUL PARK	)	Matthew Wilton for the Member

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 January 13, 14, February 11, and March 16, 2021. This matter was heard electronically.

THE ALLEGATIONS

The allegations against the Member were contained in four Notices of Hearing, dated October 29, 2018 (Exhibit 1), December 2, 2019 (Exhibit 2), January 1, 2020 (Exhibit 3) and June 15, 2020 (Exhibit 4):

Notice of Hearing H180011

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,* Statutes of Ontario, 1991, Chapter 18, in that, during the year 2016, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely J.S.S., contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - You placed implants in the patient's bone such that you caused damage to the patient's intra-alveolar nerve, and paresthesia.
   - You placed implants in the patient's bone without adequate site preparation

- You placed implants in the patient's bone without first taking measurements of the patient's bone levels.
- You placed the implants in the patient's bone without having adequate prior knowledge of the location of the patient's inferior alveolar nerve.
- You failed to advise the patient of the potential for damage to her inferior alveolar nerve when placing the implants, as well as the risks, costs and subsequent treatment that could be incurred as a result.

2. 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,* Statutes of Ontario, 1991, Chapter 18 in that, during the year(s) 2015, and 2016, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical relative to one of your patients, namely J.S.S., contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - You initiated implant treatment for the patient without the supervision of a mentor approved by the College, in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.
   - You diagnosed, consulted and treatment planned with respect to implant treatment for the patient without the supervision of a mentor approved by the College, in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.
   - In or around the year 2016, you placed implants in the patient's bone without the supervision of a mentor approved by the College in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.
   - In or around the year 2016, you removed implants from the patient's bone without the supervision of a mentor approved by the College in breach of an undertaking you provided to the College on or about April

9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.

3. 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,* Statutes of Ontario, 1991, Chapter 18 in that, during the year(s) 2015, and 2016 , you failed to abide by a written Undertaking given by you to the College or to carry out an arrangement entered into with the College, contrary to paragraph 54 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   - You initiated implant treatment for the patient without the supervision of a mentor approved by the College, in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.
   - You diagnosed, consulted and treatment planned with respect to implant treatment for the patient without the supervision of a mentor approved by the College, in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.
   - In or around the year 2016, you placed implants in the patient's bone without the supervision of a mentor approved by the College in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.
   - In or around the year 2016, you removed implants from the patient's bone without the supervision of a mentor approved by the College in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.

Allegations in Notice of Hearing H190010

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,* Statutes of Ontario, Chapter 18 in that, during the year(s) 2015, 2016 and 2017, you failed to abide by a written Undertaking given by you to the College or to carry out an arrangement entered into with the College, contrary to paragraph 54 of Section 2 of Ontario Regulation 853, Regulations of Ontario 1993, as amended.

Particulars

- You initiated implant treatment for the patients listed below without the supervision of a mentor approved by the College, in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.

Patients

- *Names of the Patients Have been redacted*

- You diagnosed, consulted and/or treatment planned with respect to implant treatment for the patients listed below without the supervision of a mentor approved by the College, in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.

Patients

- *Names of Patients Have been redacted*

- With respect to the patients listed below, you placed implants in the patient's bone without the supervision of a mentor approved by the College in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.

Patients

- *Names of Patients Have been redacted*

- With respect to the patient RH, you attempted and aborted the surgical insertion of an implant at the site of tooth 37, without the supervision of a mentor approved by the College in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other

things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.

2. 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,* Statutes of Ontario, 1991, Chapter 18 in that, during the year(s) 2015, 2016 and 2017, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members are disgraceful, dishonourable, unprofessional or unethical relative to the patients listed below, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars

   - You initiated implant treatment for the patients listed below without the supervision of a mentor approved by the College, in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.

   Patients

   - *Patient Names Have been Redacted*

   - You diagnosed, consulted and/or treatment planned with respect to implant treatment for the patients listed below without the supervision of a mentor approved by the College, in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.

   Patients

   - *Patient Names Have been Redacted*

   - With respect to the patients listed below, you placed implants in the patient's bone without the supervision of a mentor approved by the College in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.

Patients

- *Patient Names Have been Redacted*

  - With respect to the patient RH, you attempted and aborted the surgical insertion of an implant at the site of tooth 37, without the supervision of a mentor approved by the College in breach of an undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College.

  - On multiple occasions, with multiple patients, over several years, you breached the written Undertaking you provided to the College on or about April 9, 2015, that, among other things, you would restrict your practice such that you would not provide implant treatment unless under the supervision of a mentor approved by the College. Your conduct demonstrated a failure to seek advice or clarification about your obligations to the College and your patients, or blatant disregard for your obligations to the College and your patients. Your conduct calls into question your willingness to be governed by your professional regulator, the College.

Allegations in Notice of Hearing H200002

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,* Statutes of Ontario, Chapter 18 in that, during the year(s) 2017 and 2018, you failed to abide by a written Undertaking given by you to the College or to carry out an arrangement entered into with the College, contrary to paragraph 54 of Section 2 of Ontario Regulation 853, Regulations of Ontario 1993, as amended.

Particulars

- You performed implant therapy treatment for the patients listed below in breach of an undertaking you provided to the College on or about December 15, 2017 that, among other things, you would never again perform any implant therapy treatment including, but not limited to, diagnosis, treatment planning, surgical placement and/or restoration of implants.

Patients	Dates (as per chart notes)
JNJ	December 18, 2017
SJP	February 5, 2018
	February 26, 2018
	February 28, 2018
	April 19, 2018

2. 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,* Statutes of Ontario, 1991, Chapter 18 in that, during the year(s) 2017 and 2018, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical relative to the patients listed below, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- On or about December 15, 2017, you entered into a voluntary Undertaking whereby you agreed, among other things, that you would never again perform any implant therapy treatment including, but not limited to, diagnosis, treatment planning, surgical placement and/or restoration of implants.
- The Undertaking dated December 15, 2017 was the second Undertaking that you provided to the College. You provided this Undertaking after acknowledging that you breached a prior voluntary Undertaking that you provided on or about April 9, 2015, whereby you agreed to restrict your practice such that you would not initiate any new implant therapy until, and would only perform implant treatment subsequent to, successfully completing a hands-on course in implant therapy and retaining a mentor as approved by the College.
- Almost immediately after signing the second Undertaking dated December 15, 2017, you breached the Undertaking in several incidents over a five-month period, by performing implant therapy treatment for the patients listed below:

Patients	Dates (as per chart notes)
JNL	December 18, 2017
SJP	February 5, 2018
	February 26, 2018
	February 28, 2018
	April 19, 2018

- The second undertaking dated December 15, 2017 was entered into while you were represented by legal counsel. Your conduct in breaching a second Undertaking demonstrates a failure to seek advice or clarification about your obligations to the College and your patients, or blatant disregard for your obligations to the College and your patients. Your conduct has exposed your patients to harm and calls into question your willingness to be governed by your professional regulator, the College.

Allegations in Notice of Hearing H200010

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,* Statutes of Ontario, Chapter 18 in that, during the year(s) 2017 and 2018, you failed to abide by a written Undertaking given by you to the College or to carry out an arrangement entered into with the College, contrary to paragraph 54 of Section 2 of Ontario Regulation 853, Regulations of Ontario 1993, as amended.

   Particulars

   - You performed implant therapy treatment for the patients listed below in breach of an undertaking you provided to the College on or about December 15, 2017 that, among other things, you would never again perform any implant therapy treatment including, but not limited to, diagnosis, treatment planning, surgical placement and/or restoration of implants.

Patients	Dates (as per chart notes)
CSK	July 3, 2019
	August 28, 2019
	September 11, 2019
EF	April 16, 2019
	May 7, 2019
KRL	October 9, 2019

2. 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,* Statutes of Ontario, 1991, Chapter 18 in that, during the year 2019, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would

reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical relative to the patients listed below, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- On or about December 15, 2017, you entered into a voluntary Undertaking whereby you agreed, among other things, that you would never again perform any implant therapy treatment including, but not limited to, diagnosis, treatment planning, surgical placement and/or restoration of implants.
- The Undertaking dated December 15, 2017 was the second Undertaking that you provided to the College. You provided this Undertaking after acknowledging that you breached a prior voluntary Undertaking that you provided on or about April 9, 2015, whereby you agreed to restrict your practice such that you would not initiate any new implant therapy until, and would only perform implant treatment subsequent to, successfully completing a hands-on course in implant therapy and retaining a mentor as approved by the College.
- You have continued to perform implant treatment in 2019, since you signed the Undertaking dated December 15, 2017. In 2019, you breached the Undertaking 3
  dated December 15, 2017, by performing implant therapy treatment for patients, C[redacted] S[redacted] K[redacted], E[redacted] F[redacted], and K[redacted] L[redacted].
- The second undertaking dated December 15, 2017 was entered into while you were represented by legal counsel. Your repeated conduct in breaching this demonstrates a blatant disregard for your obligations to the College and your patients. Your conduct has exposed your patients to harm and calls into question your willingness to be governed by the College.

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct as set out in the Notices of Hearing, marked as Exhibits 1 through 4. With regard to the conduct, the Member admitted that his conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel confirmed with the Member that he understood his admissions and as such was satisfied that Member's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

On consent of the parties, the College introduced into evidence an Agreed Statement of Facts (Exhibit 5) which substantiated the allegations. The Agreed Statement of Facts provides as follows:

> **Allegations of Professional Misconduct**
>
> **Background**
>
> 1. Dr. Stan Sunchul Park (the "Member") has been registered with the College as a General Dentist since January 26, 1989. He received his dental degree from the University of Toronto in 1988.
>
> 2. The Member works at a clinic that he owns and operates.
>
> **The April 9, 2015 Undertaking**
>
> 3. On April 9, 2015, the Member entered into a voluntary Undertaking (the "2015 Undertaking", attached as Schedule "A"), which was given in the context of a previous complaint. The restrictions impose by the Undertaking constituted voluntary terms, conditions and limitations on the Member's certificate of registration. By that 2015 Undertaking, the Member agreed to:
>
> (a) restrict his practice such that he would not initiate any new implant therapy including, but not limited to, diagnosis, treatment planning, surgical placement and/or restoration of implants until he:
>
> (i) successfully completed a comprehensive hands-on course or courses, approved by the Registrar, in implant therapy; and
>
> (ii) retained a specialist mentor approved by the College to review and assess the adequacy of his implant treatment.
>
> (b) Only perform implant treatment subsequent to the successful completion of the course and the retention of the mentor, under the supervision of a mentor;
>
> (c) Provide evidence satisfactory to the Registrar of successful completion of the course;
>
> (d) Provide to the College an initial report from the mentor and monthly reports thereafter until the mentor is satisfied that further mentoring is not required and the ICR committee agrees.

FACTS SUPPORTING ALLEGATIONS IN NOTICE OF HEARING #1, DATED OCTOBER 29, 2018

The Member Performed Implant Procedure on J.S.S., in Breach of the 2015 Undertaking and the Standards of Practice

4. The Member performed implant treatment for a patient, J.S.S., between November 2015 and July 2016. As of the date(s) of J.S.S.'s implant treatment, the College had not approved a course or a mentor for the Member, had not received any mentorship reports, and had not been provided with proof of successful completion of any courses by the Member. The terms of the 2015 Undertaking were still in place and binding on the Member as of the date(s) of J.S.S.'s implant treatment between November 2015 and July 2016.

5. Between November 2015 and July 2016, the Member provided implant treatment to J.S.S. as follows:

   (a) On November 30, 2015, the Member saw J.S.S. related to pain and tenderness and noted that the implant teeth #35 and #36 were loose. He diagnosed advanced periodontitis in relation to both teeth, and immediately extracted both implants.

   (b) J.S.S. returned on December 14, 2015, at which time the Member observed that the #35 and #36 implant sites were healing well. He proposed to J.S.S. that he would redo those implants in May 2016.

   (c) J.S.S. returned on June 16, 2016 and the Member scheduled the replacement of implants #35 and #36 for June 30, 2016.

   (d) The Member had a discussion with J.S.S., and J.S.S. signed an informed consent form indicating that she understood the potential risks, complications and side effects. However, the Member did not discuss the risk of paresthesia with J.S.S.

   (e) The Member replaced the two implants on June 30, 2016. J.S.S. returned on July 1, 2016 because she was experiencing significant numbness below her lower lip.

   (f) The Member became concerned that there was irreversible paresthesia at that time, and he recommended the immediate removal of the two implants. The Member injected Dexamethasone (a cortical steroid) into the two sockets in an attempt to heal the nerve.

6. The Member acknowledges that given the bone loss reflected on J.S.S.'s x-rays, J.S.S. should have received bone grafting instead of

implants. The Member acknowledges that he should also have taken a 3D CBCT scan x-ray, which would have demonstrated where the nerve was. The Member further acknowledges that his actions resulted in nerve damage to J.S.S.

7. The Member's first communication with the College about compliance with his 2015 Undertaking did not occur until after he had been notified of the complaint regarding his treatment of J.S.S. (the "J.S.S. Complaint"), and after he was provided with copies of the prior College decisions related to his practice that would be considered by the ICRC in reviewing the J.S.S. Complaint, including a copy of the 2015 Undertaking.

8. On October 5, 2017, Dr. Park contacted the College and spoke to K.E., Assistant Manager, Committee Support & Enforcement. K.E's memo to file from that date (attached as Schedule "B", which the parties agree accurately summarizes the substance of the discussion) was as follows:

   Dr. Park called to tell me he had completed the mentoring program and wanted to notify the College. I informed Dr. S.P. that he was restricted from initiating new implants and that he had not completed and course and retained a mentor. He told me that he has done the course and had been paying Dr. Lin to be his mentor for over two years. He has also been doing implants. I told him that this is serious as he has a restriction on his license. I told him to get Lin to send a course completion letter and also a very detailed letter about this mentorship. I told S.P. that A.A. would send him an email outlining exactly what we need within a week to get this information for us. I told him there are no promises to what the College will do as he is in a serious breach of his U.T. S.P. could barely breathe and felt like he did everything right because Lin told him that this was the process. He said that Lin said he is releasing him from mentoring and didn't understand that the ICRC is the one to do that – based on monthly reports.

9. In providing a response to the College about the J.S.S. Complaint, dated November 9, 2017, the Member indicated that approximately two years ago Dr. Park paid Dr. Lin's office manager the sum of $5,000.00 as a deposit for mentorship fees with Dr. Lin. However, Dr. Lin was not aware of this payment or of the Member's expectation with respect to mentorship. The Member also indicated that he had completed the Ontario Academy of General Dentistry's Implant Mini Residency course with Dr. Lin, spending 126 hours on

the course. Dr. Lin had advised that Dr. Park did not contact Dr. Lin to review his cases or ask for mentorship reports, which is what Dr. Lin expected would normally have happened during a mentorship program.

10. On October 10, 2017, Dr. Lin sent an e-mail to the College (attached as Schedule "C"), indicating that:

    (a) The Member completed a comprehensive implant mini residency program in 2016;

    (b) The completed course outline meets and exceeds the current guideline requirements, with 128 CE credit hours;

    (c) As part of the course, the Member treated four cases from treatment planning to surgical implant placement and final prosthetics; and

    (d) The four implant cases were completed with clinical success and followed up accordingly.

11. Although the Member did not obtain approval from the College to use Dr. Lin as his mentor for the purposes of the 2015 Undertaking, the Registrar subsequently indicated that Dr. Lin would likely have been approved by the College if the Member had sought the required approval. The Member also did not obtain the required approval of the Registrar for the implant mini residency course.

12. The Member acknowledges that his retention of Dr. Lin and his participation in the implant mini residency course did not satisfy the requirements of the 2015 Undertaking. The Member admits that he engaged in the actions described in paragraphs 4 through 6 above while his practice was subject to restrictions under the terms of the 2015 Undertaking and that his treatment of J.S.S. was a breach of the 2015 Undertaking. His violations of the 2015 Undertaking included performing the following acts without the supervision of a mentor approved by the College:

- diagnosing, consulting, and engaging in treatment planning with respect to implant treatment for J.S.S.;
- initiating a dental implant procedure on J.S.S.;
- placing implants in J.S.S.'s bone; and
- removing implants from J.S.S.'s bone.

13. The Member's treatment of J.S.S. between November 2015 and July 2016 also contravened the standards of practice in that he:

- failed to advise J.S.S. of the potential for the damage to her inferior alveolar nerve when placing the implants, as well as the risks, costs and subsequent treatment that could be incurred as a result;
- placed implants in J.S.S.'s bone during the dental implant procedure, without preparing the site adequately, without first taking measurements of the patient's bone levels, and without having prior knowledge of the location of the patient's inferior alveolar nerve; and
- placed implants in J.S.S.'s bone in a manner that caused damage to J.S.S.'s intra-alveolar nerve, and paresthesia.

14. The Member acknowledges that his treatment of J.S.S., as outlined in paragraphs 4 through 9 above, violated the applicable standards of practice including, but not limited to, Educational Requirements & Professional Responsibilities for Implant Dentistry, approved by the College's Council in May 2013, attached as Schedule "D".

FACTS SUPPORTING ALLEGATIONS IN NOTICE OF HEARING #2, DATED DECEMBER 2, 2019

The Member Performed Implant Procedures on 22 Patients, in Breach of the 2015 Undertaking

15. The Member's response to the J.S.S. Complaint also disclosed that he had performed implant-related treatment for approximately 20 additional patients without the supervision of a mentor approved by the College and in breach of the 2015 Undertaking. In particular, on November 9, 2017, the Member sent the College a list of 18 implant cases that he acknowledges completing after signing the undertaking not to do implants.

16. On January 22, 2018, an appointment of investigators was approved to determine whether the Member had engaged in additional implant-related treatment in violation of the 2015 Undertaking. The College's investigation revealed that between April 9, 2015 and November 9, 2017, there were 22 patients for whom the Member had performed implant-related treatment without a College-approved supervisor and in breach of the 2015 Undertaking. These patients are listed in the Report of Investigation, dated April 29, 2019, attached as Schedule "E").

17. The Member treated 18 of these patients independently. On October 5, 2017, Dr. Lin reviewed these 18 cases with Dr. Park and indicated that they seemed satisfactory based on Dr. Park's records,

radiographs and models, and that he felt the treatment was clinically acceptable without compromise.

18. The Member treated the remaining 4 patients under the supervision of Dr. Lin, in the context of the implant mini residency. Dr. Lin had not been approved as a mentor by the College at the time that he treated 4 patients as part of the mini residency course, meaning that his supervision did not satisfy the terms of the 2015 Undertaking.

19. The Member initiated implant treatment, diagnosed, consulted, and/or treatment planned with respect to all 22 of the patients listed in Schedule "E". In all cases, he did so without the supervision of a College-approved mentor and in breach of the 2015 Undertaking.

20. For 20 of the 22 patients listed in Schedule "E" (all patients except for A.E.H. and S.S.K.), the treatment provided by the Member involved placing implants in the patient's bone, without the supervision of a College-approved mentor and in breach of the 2015 Undertaking.

21. For 1 of the patients listed in Schedule "E", R.H., the Member attempted and aborted the surgical insertion of an implant, without the supervision of a College-approved mentor and in breach of the 2015 Undertaking.

22. The Member acknowledges the conduct described in paragraphs 15 through 21 above constitutes a failure on his part to seek advice or clarification from the College about his obligations to the College and to his patients.

FACTS SUPPORTING ALLEGATIONS IN NOTICES OF HEARING #3 (DATED JANUARY 21, 2020) AND #4 (DATED JUNE 15, 2020)

The 2017 Interim Order and 2017 Undertaking

23. On October 5, 2017, based on its examination of the J.S.S. Complaint, the College's Inquiries, Complaints and Reports Committee imposed an interim order on the Member's certificate of registration, effective immediately. The interim order (attached as Schedule "F") stated that it would "restrict Dr. Stan Sunchul Park's practice such that he will not perform any implant therapy including, but not limited to, diagnosis, treatment planning, surgical placement, restoration and/or removal of implants". This restriction was the same as what Dr. Park had already consented to in his 2015 Undertaking.

24. On or about December 15, 2017, the Member signed a second undertaking (the "2017 Undertaking", attached as Schedule "G"), which the College agreed to accept in substitution for the 2015 Undertaking (by the ICRC's variation of its interim order, dated December 21, 2017, attached as Schedule "H"). In providing the 2017 Undertaking, the Member acknowledged that he had breached the 2015 Undertaking.

25. The 2017 Undertaking provided that, among other things, the Member would never again perform any implant therapy treatment including, but not limited to, diagnosis, treatment planning, surgical placement and/or restoration of implants. He also agreed to permit his practice to be monitored by the College by means of unannounced inspections, to ensure his compliance with the 2017 Undertaking.

26. At the time the Member entered into the 2017 Undertaking, he was represented by legal counsel. The Member acknowledges that his conduct in breaching this second undertaking to the College constitutes a failure on his part to seek advice or clarification from the College about his obligations to the College and to his patients.

The Member Performed Implant Therapy Treatment on 2 Patients, in Breach of the 2017 Undertaking

27. On May 6, 2019, a College investigator, Dr. B.F., attended the Member's office to conduct a monitoring visit. As part of that monitoring visit, he reviewed 19 patient charts. Dr. B.F. prepared a Monitoring Report, dated May 23, 2019 (attached as Schedule "I"), which the parties agree accurately summarizes the details and findings of the monitoring review and the post-monitoring visit.

28. Dr. B.F.'s review of patient charts indicated that the Member had performed implant therapy treatment to two additional patients (J.N.L. and S.J.P.) since entering into the 2017 Undertaking. Specifically:

- on December 18, 2017 (three days after entering into the 2017 Undertaking), the Member placed an implant-supported crown on J.N.L.; and
- on February 5, 2018, February 26, 2018, February 28, 2018, and April 19, 2018, the Member performed work related to implant-supported crowns for S.J.P.

29. Implant-supported crowns are considered to be restoration of an implant and were therefore precluded by the 2017 Undertaking. At

the time of his treatment of J.N.L. and S.J.P., the Member was bound by the terms of the 2017 Undertaking, which prohibited him from performing any implant therapy treatment.

30. The Member admits that he engaged in the conduct described in paragraph 28 above, and that such conduct was a violation of the 2017 Undertaking.

The Member Performed Implant Therapy Treatment on 3 Additional Patients, in Breach of the 2017 Undertaking

31. On October 21, 2019, a second unannounced monitoring visit (this time, by Dr. L.A.) took place to verify the Member's compliance with the 2017 Undertaking. Dr. L.A. prepared a Monitoring Report, dated November 11, 2019 (attached as Schedule "J"), which the parties agree accurately summarizes the details and findings of the monitoring interview and review and the post-monitoring interview.

32. Dr. L.A. reviewed 19 patient charts and concluded that the Member had performed implant-related procedures on 3 additional patients. Clinical chart entries, clinical notes, radiographs, ledger postings, and/or billing entries confirmed the Member's performance of implant-related procedures for the 3 patients in question.

33. The patient charts reviewed by Dr. L.A. indicated that:

- on April 16 and May 7, 2019, the Member performed implant therapy treatment that included the placement of an implant-supported crown on E.F.;
- on July 3, August 28, and September 11, 2019, the Member performed implant therapy treatment that included the removal of an implant from C.S.K. due to implantitis and re-screwing the implant crown; and
- on October 9, 2019, the Member performed implant therapy treatment by removing an implant crown from K.R.L. and placing a healing cap.

34. In total, these three patients had six appointments with the Member during which the Member provided care or related follow-up care for implants or restoration of implants. At the time of his treatment of E.F., C.S.K., and K.R.L., the Member was bound by the terms of the 2017 Undertaking, which prohibited him from performing any implant therapy treatment.

35. The Member admits that he engaged in the conduct described in paragraphs 31 through 34 above. He further admits that this conduct was a breach of the 2017 Undertaking.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

36. In view of the foregoing, the Member makes the following admissions of professional misconduct.

37. The Member admits that he committed professional misconduct as alleged in paragraphs 1, 2, and 3 of the Notice of Hearing dated October 29, 2018 ("Notice of Hearing #1", attached as Schedule "K"). With respect to paragraph 2 of the Notice of Hearing #1, he admits that his conduct was disgraceful, dishonourable, and unprofessional.

38. The Member admits that he committed professional misconduct as alleged in paragraphs 1 and 2 of the Notice of Hearing dated December 2, 2019 ("Notice of Hearing #2", attached as Schedule "L"). With respect to paragraph 2 of the Notice of Hearing #2, he admits that his conduct was disgraceful, dishonourable, and unprofessional.

39. The Member admits that he committed professional misconduct as alleged in paragraphs 1 and 2 of the Notice of Hearing dated January 21, 2020 ("Notice of Hearing #3", attached as Schedule "M"). With respect to paragraph 2 of the Notice of Hearing #3, he admits that his conduct was disgraceful, dishonourable, and unprofessional.

40. The Member admits that he committed professional misconduct as alleged in paragraphs 1 and 2 of the Notice of Hearing dated June 15, 2020 ("Notice of Hearing #4", attached as Schedule "N"). With respect to paragraph 2 of the Notice of Hearing #4, he admits that his conduct was disgraceful, dishonourable, and unprofessional.

ACKNOWLEDGEMENT

41. 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.

42. 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.

13. 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 #1, 2, 3, and 4.

14. 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.

15. 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.

16. 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 the Member engaged in professional misconduct as set out in the Notice of Hearing and Agreed Statement of Facts.

The Member pled guilty to the allegation as set out in the Notice of Hearing and did not dispute the facts presented in the Agreed Statement of Facts. The Member admitted to performing implant treatment on 22 patients, in direct violation of his 2015 Undertaking and an additional 5 patients, in direct violation of his 2017 Undertaking. In one instance (patient J.S.S.) the treatment resulted in paraesthesia. The Member's conduct was clearly disgraceful, dishonourable and unprofessional.

PENALTY SUBMISSIONS

At the outset of the hearing, the Panel was advised that while the parties had reached an agreement on Dr. Park's misconduct, there was no agreement with respect to penalty. The Panel received a number of additional documents and heard from three witnesses on the issue of penalty. In addition, the Panel heard over two days of submissions from counsel on the issue.

The College argued that in light of the misconduct admitted by Dr. Park in the circumstances, revocation as the only appropriate penalty to impose. Dr. Park breached his undertakings to the College and continued to perform implant procedures, when he knew or certainly ought to have known that he should not have. The College argued that the Member's excuses as to why he breached the undertakings do not justify his actions. The Member has engaged in a pattern of making promises to the College that he fails to keep and then makes excuses as to why he was unable to keep those promises. In addition to revocation, the College argued that the Panel should order a reprimand and make an order for costs in the amount of $29,000.00.

The Member acknowledged the seriousness of his misconduct, but took issue with the College's position that revocation was the only appropriate penalty. The Member testified on his own behalf, and called two additional witnesses to support his position that while he had failed to abide by the undertakings he entered into with the College, he did so because he did not fully appreciate that his actions were contrary to either undertaking. In particular, and with respect to the first undertaking given, the Member testified that he believed he was abiding by the undertaking by enrolling in an implant course and by seeking assistance and review from the course provider (Dr. Lin) on a case by case basis. He believed that by doing so, he had fulfilled the re-education and mentorship requirements of the undertaking. The course provider, Dr. Lin testified that while he never formally agreed to become Dr. Park's mentor, he did provide him with advice and mentorship from time to time on Dr. Park's implant cases. With respect to the second undertaking, the Member testified that he did not fully appreciate that any implant related work was prohibited, including repair work. The Member argued that given his good faith attempts to abide by the undertakings, a suspension of nine months, a reprimand and 36-months of monitoring were more appropriate sanctions than revocation. In addition, the Member argued that a costs order in the amount of $15,000.00 was fair.

PENALTY DECISION

The Panel considered the evidence and the parties' submissions. The Panel makes the following order:

a) The Member shall appear before the Panel of the Discipline Committee to be reprimanded within sixty (60) days of this decision becoming final or on a date to be fixed by the Registrar;
b) The Registrar is directed to revoke the Member's certificate of registration;
c) The Member is required to pay costs to the College in the amount of $29,000.00 in respect of this discipline hearing, such costs shall be payable within thirty (30) days of this decision becoming final.

REASONS FOR PENALTY DECISION

The Panel considered the evidence and submissions on penalty carefully. Revocation is a serious consequence. The Panel recognized this in coming to its decision – which it did not do lightly. In reaching its decision, the Panel took into account the seriousness of the misconduct and recognized the primary objective of its order must be public protection and the maintenance of the public's confidence in the College's ability to self- regulate. The penalty must also act as both a specific deterrent for the Member and a general deterrent for the membership at large. The Panel also considered whether this was an appropriate case for remediation or whether terms could be imposed on the Member's certificate to minimize the risk of reoffending. Finally, the Panel considered the mitigating circumstances, together with the aggravating factors in this case in coming to its conclusion.

Dr. Park repeatedly breached his undertakings with the College in both 2015 and 2017. He continued to perform implant and implant related work without having taken the steps required by the first undertaking. As a result of his repeated failure to abide by his undertakings, the Member has had two interim orders imposed upon him by the Inquiries Complaints and Reports Committee (the "ICRC"). The ICRC noted in their Interim Order of May 2020 that Dr. Park "demonstrates a pattern of blatant disregard for his obligations to the College, and for the health and safety of his patients."

Dr. Park performed an implant procedure on J.S.S. in direct contravention of his 2015 Undertaking. The patient suffered paraesthesia to her jaw. He potentially endangered other implant patients. The injury to J.S.S. occurred after Dr. Park

had completed a course in implants and could have been prevented had he taken the necessary precautions as required by the Undertaking.

The evidence demonstrated that Dr. Park treated eighteen implant cases after completing a course, but prior to securing a College-approved mentor which he was required to do pursuant to the 2015 Undertaking.

Dr. Park attempted to deflect blame and relied on the excuse that he did not understand or was confused by the plain language of the Undertaking. Not only did he act irresponsibly toward his patients by continuing to do implants when he had not fulfilled his obligations under the 2015 Undertaking, he ignored repeated attempts by the College to make him accountable and restrict his activities. Dr. Park signed the 2015 and 2017 Undertakings. There was no evidence before the Panel that he did not understand their contents at the time he signed them. With respect to the 2015 Undertaking in particular, Dr. Park knew or ought to have known that he was not to complete any implant work before he secured a College-approved mentor, who could oversee his work. The requirements of the undertakings were put in place to minimize patient risk; something Dr. Park chose to ignore.

While it might have been helpful to Dr. Park if there had been follow-up by the College after he entered into the 2015 Undertaking, it is ultimately not the responsibility of the College to ensure Dr. Park is practicing in compliance with his undertaking.

In reaching our decision, the Panel also noted that Dr. Park had a prior discipline finding. In 2013, Dr. Park was found guilty of professional misconduct and as part of the penalty ordered, was required to successfully complete a number of remedial courses, preapproved by the College. We note that Dr. Park was able to successfully comply with the 2013 penalty order, but appeared unable or unwilling to do the same with regard to the 2015 Undertaking.

The 2015 Undertaking required Dr. Park to take a College approved implant course and to retain a College approved mentor, prior to conducting any implant work. He was to comply with these obligations to the satisfaction of the ICRC. The Member failed to comply with the Undertaking. It was the Member's responsibility to ensure that he understood his obligations and that if there was any doubt, he should have followed up with the College immediately and certainly prior to recommencing implant work. The Member testified that he was confused about his obligations, but there was no evidence before the Panel

that the Member took steps to seek clarification from the College until after he had injured his patient, J.S.S.

In considering the appropriate penalty, the Panel also noted that the Member had received several problematic monitoring reports since his 2015 Undertaking. While his most recent report was positive, it did not dampen the Panel's concern regarding the prior reports.

With respect to further aggravating factors, the Panel noted that the Member's failure to abide by his undertakings over a prolonged period of time demonstrated a clear disregard for the College's regulatory processes. The Member's conduct undermines public confidence in the profession.

In 2013 a Discipline Panel found Dr. Park guilty of inappropriate billings and falsifying records. On 2 different occasions in 2019 the Member misled College investigators during office monitoring visits about performing implant related procedures which he was restricted from performing. This evidence caused the Panel to question Dr. Parks' integrity and trustworthiness.

The Member's conduct was deliberate and demonstrated a lack of care and attention for his patients and for the College's regulatory process.

Although Dr. Park appeared to show remorse for his actions and spoke of his concern for his patients' well -being, his actions demonstrated otherwise. Not only did he act irresponsibly to his patients by continuing to do implants, he ignored repeated attempts by the College to make him accountable and restrict his activities.

His admission of guilt and regret, his charitable track record and standing in his community were all commendable and mitigating factors the Panel considered. However, this did not offset the fact that he failed in his prime responsibilities to the College and the public and does not negate the professional misconduct that Dr. Park has committed.

The Panel also noted that the Member's misconduct resulted in actual harm to one of his patients.

For these reasons, the Panel concluded that the Member is ungovernable and that revocation is the only appropriate penalty in all of the circumstances. At this stage, the Panel is simply not confident that the Member can practice safely and in compliance with his obligations to the College. Should that change in future,

the Member should have to satisfy a panel of the Discipline Committee that he can return to practice safely and that he can be governed.

The penalty imposes the ultimate in public protection and acts as a strong deterrence to the profession. The College expects all members to be compliant with its rules and regulations. Further, the College expects those who have entered into undertakings with it to abide fully with their specific obligations.

With respect to the costs ordered, the Panel concluded that the amount sought by the College was reasonable in light of the fact that Dr. Park was the subject of four separate referrals and that the hearing proceeded over several days. While the Member should not be penalized for challenging the College's penalty position, other members of this profession should not bear the entire burden of the costs of the discipline process. The amount ordered represents a reasonable portion of the College's actual costs.

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

April 12, 2021

Date

CITATION: Park v. Royal College of Dental Surgeons of Ontario, 2021 ONSC 8088
DIVISIONAL COURT FILE NO.: 286/21
DATE: 20211213

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Matheson, Favreau and O'Bonsawin JJ.

BETWEEN:	)	
	)	
Dr. Stan Park	)	Matthew Wilton, for the Appellant
	)	
Appellant	)	
	)	
– and –	)	
	)	
Discipline Committee of the Royal College of Dental Surgeons of Ontario	)	M. Jill Dougherty and Debra McKenna, for the Respondent
	)	
Respondent	)	
	)	**HEARD at Toronto (by videoconference):**
	)	September 16, 2021

REASONS FOR DECISION

Favreau J.

Overview

[1] The appellant, Dr. Stan Park, appeals a decision of the Discipline Committee of the Royal College of Dental Surgeons of Ontario dated April 12, 2021, revoking his certificate of registration.

[2] Dr. Park does not appeal the findings of misconduct. He only appeals the penalty. Dr. Park argues that the Discipline Committee made several errors in principle in deciding to revoke his certificate of registration, that the reasons were insufficient and that the Committee considered irrelevant factors.

[3] For the reasons below, the appeal is dismissed. I see no errors in principle in the Discipline Committee's decision to revoke Dr. Park's certificate of registration. The decision was based on several findings of professional misconduct, including Dr. Park's persistent failure to abide by undertakings and a finding that Dr. Park lacked insight into his misconduct. In that context, the finding that Dr. Park is ungovernable was fully supported and the decision to revoke his certificate

of registration was a fit and appropriate penalty. There is also no merit to the argument that the reasons were insufficient.

Background

[4] Dr. Park received his certificate of registration from the College in January 1989. He works at a clinic that he owns and operates.

Prior findings of misconduct

[5] In 2013, the Discipline Committee found Dr. Park guilty of falsifying records, performing unnecessary dental treatment to cover up billing irregularities, and misleading College investigators. The Discipline Committee accepted a joint submission made by Dr. Park and the College, and imposed a 7-month suspension of Dr. Park's certificate of registration. The Discipline Committee also directed Dr. Park to take remedial steps, including completing courses on professional ethics, prosthodontics and recordkeeping.

Complaints and proceedings leading to the revocation decision

[6] On April 8, 2014, a patient complained that Dr. Park improperly installed dental implants and overcharged for the implants. Following the complaint, on April 9, 2015, Dr. Park voluntarily entered into an undertaking not to initiate new implant therapy until he completed a course on implants approved by the College and until the College approved a mentor to supervise his performance of further implant therapy. The undertaking also required Dr. Park to report to the College when he completed the course and required the mentor to provide monthly reports to the College (2015 Undertaking).

[7] On August 2, 2017, the College received another complaint against Dr. Park by a patient identified as J.S.S.. This patient alleged that Dr. Park performed implant treatment between November 2015 and July 2016 that resulted in nerve damage. As this procedure appeared to violate Dr. Park's 2015 Undertaking, the College conducted an investigation that revealed that Dr. Park performed 22 unauthorized implant treatments since he entered into the undertaking. The investigation also revealed that, while Dr. Park completed an implants course, he did not submit proof of completion to College. In addition, while he retained a mentor, Dr. Lin, he did not obtain the College's approval. With respect to the 22 implant patients, Dr. Park treated 18 of them without being supervised by Dr. Lin. Based on these circumstances, on October 5, 2017, the College's Inquiries, Complaints and Reports Committee made an interim order restricting Dr. Park from performing any implant therapy (2017 Interim Order).

[8] On December 15, 2017, while represented by counsel, Dr. Park signed a second undertaking to replace the 2015 undertaking (2017 Undertaking). In this undertaking, Dr. Park agreed to never again perform any implant therapy treatment and to permit the College to monitor his practice through unannounced inspections.

[9] During two monitoring inspections between 2017 and 2019, College inspectors found that Dr. Park performed implant therapy treatments on five patients in violation of the 2017 Undertaking. As a result, the Inquiries, Complaints and Reports Committee made a second interim

order on May 22, 2020 restricting Dr. Park's practice "such that he will not perform any implant therapy including, but not limited to, diagnosis, treatment planning, surgical placement, restoration and/or removal of implants". (2020 Interim Order)

[10] On a monitoring visit held November 13, 2020, the College did not find that Dr. Park was performing any implant-related treatments.

Hearing and revocation decision

[11] The allegations of professional misconduct against Dr. Park were referred to the Discipline Committee for a hearing. The allegations of professional misconduct were set out in four separate notices of hearing that dealt with the events referred to above, including the breaches of the 2015 Undertaking, the treatment of J.S.S. that led to nerve damage and the breaches of the 2017 Undertaking.

[12] Dr. Park pleaded guilty to all allegations of professional misconduct. The only issue at the hearing was the penalty to be imposed. The College sought revocation of Dr. Park's certificate of registration while Dr. Park argued that a nine-month suspension and a period of supervision would be a fit sentence.

[13] The hearing took place over four days between January and March 2021. In advance of the hearing, the parties submitted an agreed statement of facts that detailed the circumstances referred to above. The agreed statement of facts also included an acknowledgement by Dr. Park that he breached his undertakings and an acknowledgment by the College that it would have approved Dr. Lin as a mentor.

[14] Besides the agreed statement of facts, at the hearing, Dr. Park testified and called two other witnesses, including Dr. Lin.

[15] The Discipline Committee released its decision on April 12, 2021.

[16] The first few pages of the decision are taken up with a detailed review of the allegations in four Notices of Hearing that led to the hearing.

[17] The decision then goes on to state that Dr. Park "admitted the allegations of professional misconduct as set out in the Notices of Hearing… With regard to the conduct, [Dr. Park] admitted that his conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional."

[18] The decision also includes the text from the agreed statement of facts, including Dr. Park's admissions of professional misconduct.

[19] In summarizing Dr. Park's conduct, the Discipline Committee stated that he "admitted to performing implant treatment on 22 patients, in direct violation of his 2015 Undertaking and an additional 5 patients, in direct violation of his 2017 Undertaking. In one instance (patient J.S.S.) the treatment resulted in paraesthesia. The Member's conduct was clearly disgraceful, dishonorable and unprofessional."

[20] The Discipline Committee went on to review the respective positions of the parties on penalty. The College submitted that revocation was the only appropriate remedy on the basis, in part, that Dr. Park had "engaged in a pattern of making promises to the College that he fails to keep and then makes excuses as to why he was unable to keep those promises".

[21] Dr. Park argued that revocation was not appropriate in part because he did not appreciate that he was breaching his undertaking. Instead, he argued that he should be subject to a nine-month suspension, a reprimand and 36 months of supervision. In reviewing Dr. Park's submissions on penalty, the Discipline Committee referred to Dr. Park's evidence that he believed he was abiding by the undertaking:

> The Member testified on his own behalf, and called two additional witnesses to support his position that while he had failed to abide by the undertakings he entered into with the College, he did so because he did not fully appreciate that his actions were contrary to either undertaking. In particular, and with respect to the first undertaking given, the Member testified that he believed he was abiding by the undertaking by enrolling in an implant course and by seeking assistance and review from the course provider (Dr. Lin) on a case by case basis. He believed that by doing so, he had fulfilled the re-education and mentorship requirements of the undertaking. The course provider, Dr. Lin testified that while he never formally agreed to become Dr. Park's mentor, he did provide him with advice and mentorship from time to time on Dr. Park's implant cases. With respect to the second undertaking, the Member testified that he did not fully appreciate that any implant related work was prohibited, including repair work. The Member argued that given his good faith attempts to abide by the undertakings, a suspension of nine months, a reprimand and 36-months of monitoring were more appropriate sanctions than revocation. In addition, the Member argued that a costs order in the amount of $15,000.00 was fair.

[22] The Discipline Committee then went on to explain why it found that revocation was the appropriate penalty in this case. In doing so, the Discipline Committee provided the following rationale:

a. The Committee started by reviewing the general issues it was to consider in imposing a penalty, including the seriousness of the misconduct, that the "primary objective of its order must be public protection and the public's confidence in the College's ability to self-regulate", that the penalty must act as a specific and general deterrent, whether remediation or terms might address the risk of reoffending, and mitigating and aggravating factors.

b. The Committee found that Dr. Park breached the 2015 Undertaking and the 2017 Undertaking. Specifically, he continued to perform implant work without taking the steps required by the 2015 Undertaking. The Committee specifically referred to the implant work Dr. Park performed on J.S.S.. The Committee found that the "injury to J.S.S. occurred after Dr. Park had completed a course in implants and could have been prevented had he taken the necessary precautions as required by

the Undertaking". The Committee found that the evidence demonstrated that Dr. Park treated eighteen implant patients before securing a mentor, contrary to the 2015 Undertaking.

c. The Committee rejected Dr. Park's attempt to "deflect blame", finding that "he ignored repeated attempts by the College to make him accountable and restrict his activities" and that there was no evidence Dr. Park did not understand the undertakings at the time he signed them. The Committee also noted that Dr. Park made no efforts to ensure that he understood his obligations. The Committee held that the "requirements of the undertakings were put in place to minimize patient risk; something Dr. Park chose to ignore".

d. The Committee noted that Dr. Park's 2013 discipline finding related to inappropriate billings and falsifying record. The Committee also noted that Dr. Park misled College investigators twice in 2019 about whether he had performed implant work. The Committee stated that this evidence "caused the Panel to question Dr. Parks' integrity and trustworthiness"

e. The Committee noted that Dr. Park appeared to show remorse and that he has a commendable "charitable track record and standing in his community", but that "this did not offset the fact that he failed in his prime responsibilities to the College and the public".

[23] Based on these findings, the Discipline Committee concluded that "the Member is ungovernable and that revocation is the only appropriate penalty in all of the circumstances. At this stage, the Panel is simply not confident that the Member can practice safely and in compliance with his obligations to the College." The Committee went on to state in the same paragraph that "[s]hould that change in future [sic], [Dr. Park] should have to satisfy a panel of the Discipline Committee that he can return to practice safely and that he can be governed".

[24] Based on these reasons, the Discipline Committee made the following order:

a) The Member shall appear before the Panel of the Discipline Committee to be reprimanded within sixty (60) days of this decision becoming final or on a date to be fixed by the Registrar;

b) The Registrar is directed to revoke the Member's certificate of registration;

c) The Member is required to pay costs to the College in the amount of $29,000.00 in respect of this discipline hearing, such costs shall be payable within thirty (30) days of this decision becoming final.

Standard of review that applies to a penalty decision

[25] Pursuant to subsections 70(1) and (2) of the *Health Professions Procedural Code*, under Schedule 2 to the *Regulated Health Professions Act, 1991,* S.O. 1991, c. 18 (the "*Code*"), Dr. Park

has a right to appeal a decision of the Discipline Committee to the Divisional Court on a question of law or fact or both.

[26] Given the statutory right of appeal, the appellate standard of review applies: *Canada (Minister of Immigration and Citizenship) v. Vavilov*, 2019 SCC 65, at para. 37. The court is to review errors of law on a correctness standard and errors of fact or mixed fact and law, except for extricable errors of law, on a palpable and overriding standard.

[27] As held by this Court in *Mitelman v. College of Veterinarians of Ontario*, 2020 ONSC 3039, at para. 18, on an appeal from a penalty decision, the Court will only interfere if the Discipline Committee made and error in principle or if the penalty is clearly unfit:

> It is well established that in order to overturn a penalty imposed by a regulatory tribunal, it must be shown that the decision-maker made an error in principle or that the penalty was "clearly unfit." The courts in the criminal context have used a variety of expressions to describe a sentence that reaches this threshold, including "demonstrably unfit", "clearly unreasonable", "clearly or manifestly excessive", "clearly excessive or inadequate" or representing a "substantial and marked departure" from penalties in similar cases. This high threshold applies equally in the administrative law context. To be clearly unfit, the penalty must be disproportionate or fall outside the range of penalties for similar offences in similar circumstances. A fit penalty is guided by an assessment of the facts of the particular case and the penalties imposed in other cases involving similar infractions and circumstances, *College of Physicians and Surgeons of Ontario v. Peirovy*, 2018 ONCA 420 at para. 56.

Issue 1 – Did the Discipline Committee make any errors in principle in revoking Dr. Park's certificate of registration?

[28] Dr. Park argues that the Discipline Committee made a number of errors in principle in its decision to revoke his registration. Specifically, he argues that the Discipline Committee failed to consider any precedents to ensure that revocation falls within the range of appropriate penalties for similar offences and to ensure that the penalty was proportional to the offences. He also argues that the Discipline Committee failed to define and apply the legal test for ungovernability.

[29] I do not find that the Discipline Committee made any errors in principle.

[30] In making the argument that the Discipline Committee failed to consider similar cases to assess whether revocation was a fit and proportionate penalty, Dr. Park relies on the Court of Appeal's decision in *College of Physicians and Surgeons of Ontario v. Peirovy*, 2018 ONCA 420. In *Peirovy*, at para. 57, the Court of Appeal held that, in determining whether a penalty is "clearly unfit", the Court should be guided by proportionality and an assessment of the range of appropriate penalties dependent upon the facts of each case and penalties imposed in other similar cases.

[31] Dr. Park suggests that this case requires the Discipline Committee to explicitly consider and refer to other similar cases in its decision. However, this is not what the Court of Appeal held in *Peirovy*. It held that, in order to be found unfit, as sentence must be disproportionate to the

circumstances of the offence and fall outside the range of penalties for similar offences. The Court did not hold that the Discipline Committee must *explicitly* cite other decisions involving similar circumstances. There is no doubt that citing other cases would be preferable, but the failure to do so is not an error in principle. The Discipline Committee only committed an error in principle if Dr. Park can demonstrate that the penalty actually falls outside the range for penalties in similar circumstances.

[32] However, for the purpose of this appeal, Dr. Park did not put forward any cases that demonstrate that revocation in this case falls outside the range of penalties in similar circumstances. This is not surprising. The Discipline Committee's decision was based on a finding that Dr. Park deliberately and repeatedly disregarded his undertakings to the College. On at least one occasion, this conduct harmed a patient. On its face, revocation is a fit sentence because it addresses the concern that Dr. Park cannot be counted on to abide by further conditions or limitations imposed on his ability to practice dentistry. In the absence of a clear line of cases showing that the Discipline Committee has not imposed revocation in similar cases, I do not find that the Discipline Committee made an error in principle by failing to refer to specific similar cases in its decision.

[33] Dr. Park also argues that the Discipline Committee made an error in principle by failing to review the test that applies to deciding whether a member of a profession is ungovernable. This argument is similar to the alleged error discussed above. Dr. Park does not argue that the Discipline Committee made an error in principle in finding that the circumstances of this case meet the test for a finding of ungovernability. Rather, he argues that the Committee erred by failing to explicitly address the test.

[34] In making this argument, Dr. Park states that, at the hearing before the Discipline Committee, his counsel and counsel for the College referred to the Law Society Tribunal's decision in *Law Society of Upper Canada v. Robin Douglas Scott*, 2006 ONLSHP 48, at para. 17 and 18, which sets out the following test for ungovernability:

> [17] The jurisprudence does not draw a bright line for the determination of ungovernability nor does the manifestation of the behavior automatically mean disbarment.
>
> [18] Factors which inform the determination whether a member is ungovernable include the following:
>
> (a) the nature, duration and repetitive character of the misconduct;
>
> (b) any prior discipline history;
>
> (c) any character evidence;
>
> (d) the existence or lack of remorse. Remorse includes a recognition and understanding of the seriousness of the misconduct;
>
> (e) the degree of willingness to be governed by the Society;

(f) medical or other evidence that explains (though does not excuse) the misconduct;

(g) the likelihood of future misconduct, having regard to any treatment being undertaken, or other remedial efforts;

(h) the member's ongoing co-operation with the Society in addressing the outstanding matters that are the subject of the misconduct.

[35] Again, Dr. Park points to no case that supports his argument that the Discipline Committee must explicitly refer to a test or case law before making a finding of ungovernability. However, it is evident from the Discipline Committee's reasons that it did consider the relevant factors listed above, including the following:

a. The Committee considered that Dr. Park breached two undertakings over several years and that, in one case, this resulted in an injury to a patient;

b. The Committee considered that Dr. Park had already been found liable for professional misconduct involving matters relevant to his character and integrity;

c. The Committee did consider the evidence of Dr. Park's charitable work, but found that it did not offset against the seriousness of the misconduct;

d. The Committee considered that Dr. Park expressed remorse but found that he did not appear to understand the seriousness of his misconduct given the excuses he offered;

e. The Committee made several findings that Dr. Park did not appear to be willing to be governed by the College, including the finding that he "chose to ignore" his undertakings; and

f. There was no medical evidence or other evidence to explain his misconduct, other than his excuses about not understanding the undertakings, explanations the College explicitly rejected.

[36] In my view, the Discipline Committee committed no errors in principle nor has Dr. Park demonstrated that the penalty is clearly unfit. In revoking Dr. Park's licence, the Discipline Committee had regard to Dr. Park's ongoing failure to comply with his undertakings and the potential risk this poses to public safety and confidence.

Issue 2 – Are the Discipline Committee's reasons deficient?

[37] Dr. Park argues that the Disciplinary Committee's reasons are so deficient that this amounts to an error of law. I see no merit to this argument.

[38] In *R. v. R.E.M.*, 2008 SCC 5, at para. 15, the Supreme Court of Canada explained that courts should take a functional approach to assessing the sufficiency of reasons: "reasons must be

sufficient to fulfill their functions of explaining why the accused was convicted or acquitted, providing public accountability and permitting effective appellate review". At para. 17, the Court held that the "foundation" of the decision "must be discernable, when looked at in the context of the evidence, the submissions of counsel and the history of how the trial unfolded".

[39] In *Mitelman*, at paras. 29-31, this Court addressed a similar argument regarding the sufficiency of reasons in the context of a penalty decision. In that case, at para. 30, the Court held that "[i]f the reasons state their conclusions in brief compass and these conclusions are supported by the evidence, the decision will not be overturned merely because it fails to discuss every aspect or issue relevant to the case".

[40] I am satisfied that the Discipline Committee's reasons are sufficient to explain why the Committee concluded that revocation was appropriate in he circumstances of this case. As reviewed above, the reasons set out the full text of the four Notices of Hearing and the agreed statement of fact. These documents provide the details of the allegations against Dr. Park, including his agreement that he has committed professional misconduct. The decision also sets out some evidence provided by Dr. Park about his explanations for not abiding by his undertakings. In the analysis section, the Discipline Committee explains the basis for finding that revocation is an appropriate remedy, including the finding that Dr. Park is ungovernable given his ongoing pattern of failing to abide by his undertakings. This is not a borderline case. The reasons are more than sufficient to explain why the Discipline Committee came to its conclusion.

[41] Dr. Park argues that the Committee failed to address his evidence and make any findings of fact. I do not accept this argument. This is a case in which there was an agreed statement of facts and therefore there were very few findings of fact to be made. Insofar as Dr. Park complains that the Discipline Committee did not consider his evidence regarding his explanation for failing to comply with the undertaking, the Discipline Committee did consider the evidence but it did not accept it. Dr. Park's evidence was that he misunderstood his obligations. However, the Committee found that there was no evidence that he did not understand his obligations at the time he signed the undertakings and that he made no efforts to clarify his obligations. Similarly, the Discipline Committee considered Dr. Park's mitigation evidence but found that it was not sufficient to mitigate against the seriousness of the misconduct.

[42] Dr. Park's complaint is really that the Discipline Committee did not accept his evidence and submissions. This is not a problem with the sufficiency of reasons.

Issue 3 – Did the Discipline Committee take account of an irrelevant consideration?

[43] Dr. Park takes issue with the following highlighted statement at the end of the Discipline Committee's decision:

> For these reasons, the Panel concluded that the Member is ungovernable and that revocation is the only appropriate penalty in all of the circumstances. At this stage, the Panel is simply not confident that the Member can practice safely and in compliance with his obligations to the College. **Should that change in future, the**

> **Member should have to satisfy a panel of the Discipline Committee that he can return to practice safely and that he can be governed.** [Emphasis added.]

[44] Dr. Park argues that the Discipline Committee improperly placed the onus on him to prove that he can be governed by the College. He takes the position that this is an irrelevant consideration.

[45] This statement cannot be read in isolation. It comes at the end of the Discipline Committee's comprehensive review of its reasons for finding that revocation was appropriate in this case. Read as a whole, the Discipline Committee's decision makes clear that it did not decide to revoke Dr. Park's certificate of registration because he should have to prove that he can be governed. Rather, the Discipline Committee revoked his certificate because of his persistent failure to abide by his undertakings. In this context, the reference to what Dr. Park will have to do to return to practice is simply a statement of fact. Given that his certificate of registration was revoked on the basis of his failure to comply with his undertaking and putting at least one patient at risk, he will only be able to return to practice if he can demonstrate that he no longer presents these risks.

Conclusion

[46] For the reasons above, the appeal is dismissed.

[47] As agreed between the parties, as the successful party, the College is entitled to costs of $20,000 plus its disbursements, for a total of $25,575.98. This amount is to be paid within 30 days, unless the parties agree otherwise.

Favreau J.

Favreau J.

I agree

Matheson J.

I agree

O'Bonsawin J.

Released: December 13, 2021

CITATION: Park v. Royal College of Dental Surgeons of Ontario, 2021 ONSC 8088
DIVISIONAL COURT FILE NO.: 286/21
DATE: 20211213

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Matheson, Favreau and O'Bonsawin JJ.

BETWEEN:

Dr. Stan Park

Appellant

– and –

Discipline Committee of the Royal College of Dental Surgeons of Ontario

Respondent

REASONS FOR DECISION

Favreau J.

Released: December 13, 2021

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.

You will be given an opportunity to make a statement at the end of the reprimand if you wish.

The panel has found that you have engaged in multiple acts of professional misconduct. In particular:

- On multiple occasions you breached two separate voluntary Undertakings that you made with the ICRC. Implant procedures were performed on approximately 20 patients in contravention of the terms of the 2015 Undertaking. This Undertaking was intended to protect patients and provide you with an opportunity to improve your knowledge and skills when performing implant therapy. Your disregard for that Undertaking and its' requirements unfortunately resulted in irreparable harm to a patient. Had you followed the terms of the Undertaking this misadventure more than likely would not have occurred.
- After denying performing any implant procedures, a College inspector found that you had once again performed implant related procedures in contravention of your 2017 Undertaking.

The cumulative effect of your conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional and unethical.

Your professional misconduct is a matter of profound concern. It is completely unacceptable to your fellow dentists and to the public. You have brought discredit to the entire profession and to yourself. Public confidence in this profession has been put in jeopardy.

Of special concern to us is the fact that the professional misconduct in which you engaged has involved a repeated pattern of disregard for the College, the undertakings you gave to the College, the level of deceit attached to much of your conduct and the serious deflection of blame you exhibited throughout.

- In 2013, a Discipline Panel found you guilty of falsifying records.
- You breached a 2015 Undertaking treating numerous implant related patients which caused serious bodily harm to one patient.
- You misled College investigators, denying that you performed implant related procedures which contravened a 2017 Undertaking.

You offered a lack of understanding the terms of the Undertakings as an excuse for your misconduct. However, you managed to successfully comply with the Penalty Order from your 2013 misconduct hearing without any confusion or misunderstanding. You did not seek assistance or clarification for the terms of either Undertaking. This certainly brings into question your integrity and trustworthiness.

We have ordered the penalty of revocation, being the most significant penalty this Committee can impose. It is appropriate because your conduct was deliberate and demonstrated a lack of care and attention for your patients and for the College's regulatory process. To paraphrase from the ICRC's Interim Order of May 2020 Dr Park "demonstrates a pattern of blatant disregard for his obligations to the College, and the health and safety of his patients." As a result, as you know from our decision, this Panel considers you to be ungovernable.

As I advised earlier, you will now be given an opportunity to make a comment if you wish to do so. This is not an opportunity for you to debate the merits or the correctness of the decisions we have made.

Do you have any questions or do you wish to make any comments?

Thank you for attending today. We are adjourned.