IN THE MATTER OF	*	**BEFORE THE**
JUN PARK, D.D.S.	*	**MARYLAND STATE BOARD**
Respondent	*	**OF DENTAL EXAMINERS**
License Number: 13401	*	**Case Number: 2018-198**

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CONSENT ORDER

On or about September 25, 2020, the Maryland State Board of Dental Examiners (the "Board") charged **JUN Y. PARK, D.D.S.** (the "Respondent"), License Number 13401, with violating the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol. & 2019 Supp.) and Md. Code Regs. ("COMAR") 10.44 *et seq.*

Specifically, the Board charged the Respondent with violating the following provisions of the Act under Health Occ. § 4-315 and COMAR 10.44 *et. seq.*:

> **Health Occ. § 4-315. Denials, reprimand, probations, suspension, and revocations— Grounds.**
>
> (a) *License to practice dentistry* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may … reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the … licensee:
>
> (6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession:
>
> (19) Provides a dental service in a manner that is significantly inconsistent with generally accepted professional standards of

care in the practice of dentistry, regardless of whether actual injury to the patient occurs; [and]

(20) Violates any rule or regulation adopted by the Board[.]

COMAR 10.44.23.03 Unprofessional or Dishonorable Conduct [1]

A. A dentist . . . may not engage in unprofessional or dishonorable conduct.

B. The following shall constitute unprofessional or dishonorable conduct in the practice of dentistry . . .:

(2) Engaging in conduct which is unbecoming a member of the dental profession; [and]

(8) Committing any other unprofessional or dishonorable act or omission in the practice of dentistry[.]

On December 2, 2020, a Case Resolution Conference ("CRC") was held by videoconference with a panel of the Board. As a resolution of this case, the Respondent agreed to enter into this Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board finds the following facts.

I. BACKGROUND

1. At all times relevant, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in Maryland on or about August 12, 2003, under License Number 13401. The Respondent's license is

[1] Effective July 17, 2017, the regulation was recodified from COMAR 10.44.23.01 to COMAR 10.44.23.03 without substantive modifications.

currently active and expires on June 30, 2021. This is Respondent's first disciplinary matter before the Board.

2. At all times relevant, the Respondent practiced dentistry at a practice in Lutherville-Timonium, Maryland (the "Practice").[2]

3. On or about April 12, 2018, the Board initiated an investigation of the Respondent after reviewing information from the Maryland Healthcare Alternative Dispute Resolution Office regarding a dental malpractice claim a patient (the "Patient") filed against the Respondent. The claim alleged that the Respondent failed to properly and timely diagnose a cancerous lesion on the Patient's left retro molar area. The claim also alleged that misdiagnosis by the Respondent resulted in lost teeth and jaw bone disfigurement. The Respondent denied wrongdoing in the civil litigation.

4. According to the National Practitioner Data Bank, in or around November 2018, the Respondent's insurance company settled the claim. The terms of the settlement are confidential.

II. BOARD'S INVESTIGATION

5. In the course of its investigation, the Board subpoenaed the Patient's dental records from the Respondent and submitted them to a licensed dentist (the "Board Expert") who specialized in oral and maxillofacial surgery for a review.[3] Based on his review, the Board

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[2] To protect confidentiality, the name of the Complainant, patients, other dentists or dental practices will not be identified by name in this document. The Respondent may obtain the identity of all individuals/entities referenced herein by contacting the assigned administrative prosecutor.

[3] The Board expert is also a licensed physician in Maryland.

Expert determined the Respondent deviated significantly from the standard of care by failing to provide enough attention and follow-through to a Patient with a suspicious oral lesion, particularly when the Patient had a known history of heavy tobacco use.

6. The Patient, a male, then 57 years old, initially presented to the Respondent's Practice on January 17, 2013. The Patient filled out a medical history form on his first visit, in which he indicated he smoked tobacco products.

7. On April 10, 2015 the Respondent saw the Patient at an emergency appointment for pain in the Patient's upper left quadrant. During the visit, the Respondent noted the presence of a lesion in the left retro molar area on the Patient's chart. The Respondent also noted the Patient should return in one month for a follow-up visit to monitor the lesion. The Patient did not appear for the follow-up appointment.

8. The Patient did not return to the Respondent's Practice until August 7, 2015.[4] The Respondent noted that the lesion was slightly bigger and performed an oral brush biopsy test. The Respondent stated in his narrative of care, submitted in response to the Board's investigation, that he wanted to refer the Patient to an oral surgeon for a surgical biopsy. However, this idea was not noted anywhere in the Patient's contemporaneous records.

9. The Respondent received the results of the oral brush biopsy on August 13, 2015, which indicated the lesion was a fungal infection. The Respondent prescribed the Patient antibiotics to treat the lesion and instructed the Patient to return in a month.

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[4] The Patient's dental chart maintained by the Respondent documents no attempts by the Respondent or his Practice to contact the Patient between April 2015 and August 2015.

10. On September 14, 2015 the Respondent saw the Patient again for a follow-up visit. The Respondent noted in the Patient's chart that while the lesion's appearance was improved, it was still present and open. He stated in his narrative of care that although five weeks had passed since the initial brush biopsy, the Respondent felt a tissue incisional biopsy was unnecessary.

11. On October 25, 2015, the Respondent treated the Patient for an emergency visit where a restoration had fallen out of one of the Patient's teeth. The Respondent stated in his narrative of care that he did not have time to evaluate the lesion during this visit and focused only on the emergency condition. The lesion is not mentioned in the patient records from this visit.

12. The Patient returned to the Practice again on November 9, 2015. At this visit, the Respondent reevaluated the lesion, which showed no signs of improvement. The Patient also said the area was painful. The Respondent suggested the Patient see an oral surgeon to receive a biopsy.

13. The Patient received a biopsy from an oral surgeon. According to the Respondent's narrative of care, the Respondent was contacted at some point regarding the results of the biopsy. The biopsy indicated the Patient's lesion was squamous cell carcinoma that would require extensive surgery.[5] It took seven months from the initial discovery of the lesion for the Patient to receive a proper diagnosis.

[5] A review of the Patient's chart maintained by the Respondent reveals the Respondent failed to document when he was notified of this diagnosis or who notified him.

14. Based on the Board Expert's review, the Respondent's care and treatment of the Patient was professionally and grossly incompetent and deviated significantly from professional standards of care for reasons including:

a. Failing to timely recognize and diagnose a cancerous lesion.

b. Failing to appropriately follow up with the Patient regarding the lesion.

c. Failing to timely refer the Patient for a surgical biopsy.

d. Failing to act with appropriate urgency and to communicate the potential severity of the lesion to the Patient.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's conduct, as described above, constitutes violations of the Act as cited above, specifically: practicing dentistry in a professionally incompetent manner or in a grossly incompetent manner, in violation of Health Occ. § 4-315(a)(6); behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. § 4-315(a)(16); providing a dental service in a manner that is significantly inconsistent with generally accepted professional standards of care in the practice of dentistry, regardless of whether actual injury to the patient occurs, in violation of Health Occ. § 4-315(a)(19); and violating any rule or regulation adopted by the Board, *i.e.* COMAR 10.44.23.03.

ORDER

It is, by the Board, hereby:

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that from the effective date of this Consent Order, the Respondent shall be placed on **PROBATION** for a minimum period of **24 (TWENTY-FOUR) MONTHS** and continuing until he has satisfactorily completed the following terms and conditions:

1. The Respondent is fined in the amount of **TWO THOUSAND FIVE HUNDRED DOLLARS ($2500)**, due to the board within one (1) year of the effective date of this Consent Order;

2. Within six (6) months of the effective date of this Consent Order, the Respondent shall successfully complete an in-person (or, if in-person courses are not available due to the current State of Emergency, then by video-conference) two (2) credit hour course(s), approved by the Board in advance, in professional ethics.

3. Within six (6) months of the effective date of this Consent Order, the Respondent shall successfully complete an in-person (or, if in-person courses are not available due to the current State of Emergency, then by video-conference) four (4) credit hour course(s), approved by the Board in advance, in dental recordkeeping.

4. Within six (6) months of the effective date of this Consent Order, the Respondent shall successfully complete an in-person (or, if in-person courses are not available due to the current State of Emergency, then by video-conference) eight (8) credit hour course(s), approved by the Board in advance, in oral pathology.

5. For a minimum period of six (6) months from the effective date of this Consent Order, and continuing until the Respondent has successfully completed probationary condition (4) (the 8-credit oral pathology course(s)), the Respondent shall not treat any patients presenting any oral pathology-related condition, and instead shall immediately refer those patients to an appropriate treatment provider.

6. The Respondent may file a petition for early termination of his probation after one (1) year from the effective date of this Consent Order. After consideration of the petition, the Board, or a designated committee of the Board, shall grant the petition if the Respondent has satisfactorily complied with the terms and conditions of this Consent Order.

AND IT IS FURTHER ORDERED that no part of the training or education that the Respondent receives in order to comply with this Consent Order may be applied to his required continuing education credits, and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with the Board-assigned inspector, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order, and it is further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that after a minimum of two (2) years from the effective date of the Order for Reinstatement, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board. The Board shall grant termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending investigations or outstanding complaints related to the findings of fact in this Consent Order; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be an evidentiary hearing before the Board. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board; and it

is further

ORDERED that after the appropriate hearing, if the Board determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice dentistry in Maryland. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Md. Code Ann., Gen. Prov. §§ 4-101 et seq. (2014).

2/4/2021
Date

Francis X. McLaughlin, Jr., Executive Director
Maryland State Board of Dental Examiners

CONSENT

By this Consent, I, Jun Park, D.D.S., agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and

enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having had the opportunity to consult with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its effect.

1/3/21
Date

Jun Park, D.D.S.
The Respondent

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF: BALTIMORE

I HEREBY CERTIFY that on this 30TH day of JANUARY 2021 ~~2020~~, before me, a Notary Public of the State and County aforesaid, personally appeared[6] Jun Park, D.D.S., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires: 9/18/2023

[6] During the current State of Emergency, and in compliance with the Governor's emergency orders, notarization may be accomplished remotely.