STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Joel O. Diven
Docket No.: 06-10-A-1023DE
Document: Statement of Charges

Regarding your request for information about the above-named practitioner, certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld:

> The identity of the complainant if the person is a consumer, health care provider, or employee, pursuant to RCW 43.70.075 (Identity of Whistleblower Protected) and/or the identity of a patient, pursuant to RCW 70.02.020 (Medical Records - Health Care Information Access and Disclosure)

If you have any questions or need additional information regarding the information that was withheld, please contact:

> Customer Service Center
> P.O. Box 47865
> Olympia, WA 98504-7865
> Phone: (360) 236-4700
> Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Deputy Secretary, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
DENTAL QUALITY ASSURANCE COMMISSION

In the Matter of **JOEL O. DIVEN** Credential No. DE00003155 Respondent	**Docket No. 06-10-A-1023DE** **STATEMENT OF CHARGES**

The Deputy Executive Director, on designation by the Dental Quality Assurance Commission (Commission) makes the allegations below, which are supported by the evidence contained in program file number 2006-07-0002DE. The patient referred to in this Statement of Charges is identified in the attached Confidential Schedule.

1: ALLEGED FACTS

1.1 Respondent, Joel O. Diven, was issued a credential to practice as a dentist by the state of Washington in January 1963. Respondent's credential is currently active.

1.2 On May 24, 2006, in the course of attempting an extraction of Patient A's upper second molar (tooth #2), Respondent fractured Patient A's upper jaw bone and proceeded to destructively remove a half-dollar size portion of the jaw bone, the tuberosity, tooth #2 and adjacent third upper molar (tooth #1). Patient A suffered profuse uncontrolled bleeding, the soft palate tissue was torn to mid-point and the floor of the maxillary sinus was torn out, leaving a gaping hole exposing muscle and hanging upper sinus tissue.

1.3 Respondent abandoned the patient at the conclusion of the extraction, without attempting to close the surgical wound or otherwise assist Patient A, who was suffering ongoing profuse bleeding, dropping blood pressure, and compromised airway.

1.4 Throughout the extraction, for approximately two and one-half hours, Respondent exhibited callous disregarded for the pain and injury he was inflicting upon Patient A.

//

//

ORIGINAL

1.5. Respondent failed to appreciate that the appropriate response to the feel and sound of Patient A's broken jaw was to stop the extraction process until proper x-ray and testing could be conducted to identify the condition and determine a prudent course of action, particularly in light of the close proximity of the maxillary sinus in the area. The feel of the broken portion of the jaw bone shifting as he pulled on the tooth should have alerted Respondent to the maxillary fracture. Accurate assessment of the fracture would have allowed an oral surgery referral, and could have preserved the integrity of the Patient's maxilla and avoided further injury.

1.6 Prior to, during, and after this extraction procedure, Respondent failed to follow basic safeguards and standards of general dentistry in his care of Patient A, including:

1.6.1 Failure to obtain and consider an adequate patient history.

1.6.2 Failure to ensure informed consent of the patient.

1.6.3 Failure to conduct proper diagnostic testing to determine if there was a need to extract tooth #2.

1.6.4 Failure to obtain a current x-ray of tooth #2 or the upper jaw area.

1.6.5 Failure to adequately assess an older radiograph available in the patient chart, which showed the close proximity of tooth #2 to the maxillary sinus and an impacted adjacent third molar (tooth #1).

1.6.6 Failure to recognize the distinctive feel and sound indicative of a jaw fracture.

1.6.7 Failure to stop and follow proper technique at the point of suspecting a jaw fracture, or in the alternative failure to contact a more expert dentist or oral surgeon at that point.

1.6.8 Failure to address Patient A's pain, either by providing additional local anesthetic or stopping the procedure until general anesthesia could be made available.

1.6.9 Failure to initiate treatment for Patient A's profuse bleeding during the procedure.

1.6.10 Failure to maintain adequate dental records for Patient A.

1.6.11 Respondent perforated the root of Patient A's lower first molar (tooth #30) two days earlier, on May 22, 2006, by aggressively placing three files in one canal, causing one to extend out the apex of the root by approximately 3mm. This condition was x-rayed, but that radiograph is now missing from Patient A's records.

1.7 Following Patient A's stabilization, significant defects remained, including an exposed sinus and insufficient bone support for tooth #3, which jeopardizes the health of that tooth. Patient A suffers ongoing pain and dysfunction caused by this botched procedure.

1.8 Respondent failed to report this May 24, 2006, incident to the Dental Quality Assurance Commission until June 29, 2006; despite knowing that such self-report was due within thirty (30) days of the incident.

2: ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(4), (7), and (24), WAC 246-817-310, WAC 246-817-320 and WAC 246-817-380 which provide in part:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:
>
> . . .
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
>
> . . .
>
> (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
>
> . . .
>
> (24) Abuse of a client or patient
>
> . . .

WAC 246-817-310 Maintenance and retention of records. Any dentist who treats patients in the state of Washington shall maintain complete treatment records regarding patients treated. These records shall include, but shall not be limited to X rays, treatment plans, patient charts, patient histories, correspondence, financial data and billing. These records shall be retained by the dentist for five years in an orderly, accessible file and shall be readily available for inspection by the DQAC or its authorized representative: X rays or copies of records may be forwarded to a second party upon the patient's or authorized agent's written request. Also, office records shall state the date on which the records were released, method forwarded and to whom, and the reason for the release. A reasonable fee may be charged the patient to cover mailing and clerical costs.

Every dentist who operates a dental office in the state of Washington must maintain a comprehensive written and dated record of all services rendered to his/her patients. In offices where more than one dentist is performing the services the records must specify the dentist who performed the services. . . .

...

WAC 246-817-320 Report of patient injury or mortality. All licensees engaged in the practice of dentistry shall submit a complete report of any patient mortality or other incident which results in temporary or permanent physical or mental injury requiring hospitalization of said patient during, or as a direct result of dental procedures or anesthesia related thereto. This report shall be submitted to the DQAC within thirty days of the occurrence.

WAC 246-817-380 Patient abandonment. The attending dentist, without reasonable cause, shall not neglect, ignore, abandon, or refuse to complete the current procedure for a patient.

... .

2.2 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

//

//

//

3: NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare. The Deputy Executive Director of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline pursuant to RCW 18.130.180 and the imposition of sanctions under RCW 18.130.160.

DATED: October 26, 2006.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
DENTAL QUALITY ASSURANCE
COMMISSION

Kirby Putscher

KIRBY PUTSCHER
DEPUTY EXECUTIVE DIRECTOR

Steve C

STEPHEN CARPENTER, JR., WSBA #26184
ASSISTANT ATTORNEY GENERAL

FOR INTERNAL USE ONLY: **PROGRAM NO. 2006-07-0002DE**

CONFIDENTIAL SCHEDULE

This information is confidential and is NOT to be released without the consent of the individual or individuals named herein. RCW 42.56.240(1)

Patient A [redacted]