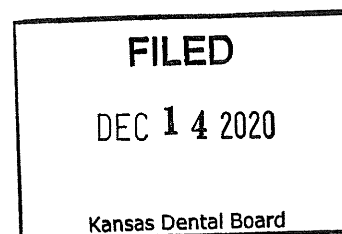
BEFORE THE KANSAS DENTAL BOARD

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| *In The Matter Of* | ) | |
| | ) | Case No. 20-7 |
| MICHAEL PUTNAM, DDS | ) | |
| LICENSE NO. 5899 | ) | |

# EMERGENCY AGENCY ORDER

Michael Putnam, DDS ("Respondent") is currently authorized to practice dentistry in the State of Kansas by reason of the Kansas Dental Board ("Board") having issued him License No. 5899.

The following facts related to the Respondent's practice of dentistry in the State of Kansas has come to the attention of the Board's Investigation Committee:

1. As the result of a complaint received, the Board issued a Stipulation and Agreement regarding Respondent's dental practice on April 12, 1990.

2. As the result of a complaint received, the Board issued a Joint Stipulation and Agreed Order regarding Respondent's dental practice on September 10, 1991.

3. As the result of a complaint received, the Board issued a Letter of Concern to Respondent on November 14, 2013 addressing the excessive use of Lidocaine and Respondent's need to have an office assistant present during business hours.

4. On October 13, 2016, the Board received a Complaint in which the Complainant alleged uncleanly conditions in Respondent's office. In August 2017, during the subsequent investigation the Board's Investigator Steve Johnson, DDS went to Respondent's dental practice at which time Respondent threw his glasses and violently slammed his fist into a wall and a door accusing Dr. Johnson of trying to destroy him.

5. In early 2018, the Board received an anonymous complaint forwarded by the Kansas Department of Children and Families alleging, among other things, that Respondent

became unreasonably angry during treatment and did not wear gloves during an oral examination.

6. During January 2018, representatives of the Board other than Dr. Johnson visited Respondent's office. Their findings included:

a. Respondent appeared disheveled and his hands did not appear clean;

b. Respondent's records did not seem organized;

c. Respondent had no x-ray view box;

d. Observed x-rays appeared of questionable quality; and

e. Respondent's Dri-clave sanitizer was in a generally dirty lab area.

7. On December 26, 2017, the Board received a complaint in which the Complainant alleged, among other things, that at multiple visits Respondent became frustrated and threw dental instruments against the wall. The subsequent investigation disclosed that although the patient requested upper and lower immediate dentures, Respondent failed to take a full-mouth X-ray series which would be the standard of care before initiating such treatment.

8. On May 17, 2018, the Board received a complaint alleging, among other things, that Respondent became angry and threw one or more dental instruments. The subsequent investigation determined the Respondent failed to x-ray tooth #12 before treating with a temporary crown and that Respondent left large amounts of cement subgingival at #30 and #31 and interproximal between #29, #30 and #31, all of which was below the applicable standard of care. It also appeared Respondent may have left significant calculus behind at a February 2018 cleaning he performed.

9. In November 2018, the Board received a complaint in which the Complainant alleged Respondent was unprofessional and accused the Complainant of being a deadbeat.

10. On February 19, 2019, the Board received a complaint in which the Complainant alleged Respondent's office was dirty, and that Respondent put his hands in the Complainant's mouth without wearing gloves.

11. On March 26, 2019, the Board received a complaint in which the Complainant alleged that Respondent twice threw a dental instrument across the treatment room. The subsequent investigation revealed that the amount of Lidocaine administered to the patient was excessive for the procedure performed.

12. The Board's dentist Investigator, Dr. Johnson, performed a review of selected patient records. Dr. Johnson's findings included:

a. Many records, regardless of treatment, showed the administration of 300 mg Lidocaine for local anesthetic which for the situations involved was excessive;

b. In some instances, prescriptions written for narcotics were not reflected in the patient's record;

c. In some instances, patient visits at which narcotics were prescribed by Respondent were not recorded in the patient's record;

d. In some instances, the type, strength, and amount of local anesthetic did not appear in the patient's record for appointments at which Respondent performed tooth extractions;

e. In some instances, x-rays were not diagnostic for the treatment performed or were missing from the patient's record;

f. In most instances the patient's record had a recordkeeping error and in some instances had no entry for treatment dates; and

g. Respondent prescribed excessive amounts of oxycodone to tooth extraction patients both at the time of the extraction and subsequently.

13. On November 4, 2020, patient AA presented at Respondent's dental office in Topeka Kansas complaining of pain related to tooth #30. Respondent determined to surgically remove the tooth. Respondent performed the procedure without an assistant of any kind to assist

with suctioning or retracting the tongue or gum. Respondent failed to remove the root tip of #30 and failed to take a post extraction x-ray. Another dentist that saw patient AA later on the same day found that Respondent had caused a 2.5 cm x 1 cm tear of the floor of the patient's mouth and iatrogenic grooves in the buccal bone of #30. The dentist also found that Respondent while using a burr had caused a groove in the lingual plate that extended through the bone and the tissue with a through and through fistula. Respondent's patient record for the treatment of patient AA on November 4, 2020 does not reflect that he advised the patient of the unnecessary damage that had been done to the patient's mouth.

After considering the foregoing, the Board's Investigation Committee, in accordance with the authority granted to it by the Board, enters the following emergency agency order, pursuant to K.S.A. 77-536 and K.S.A. 65-1449.

## I. FINDINGS OF FACT

For purposes of this order, the Board's Investigation Committee makes the following findings of fact:

1. The Board has previously issued Respondent license number 5899, which entitles him to practice dentistry in the State of Kansas ("Respondent's License").

2. The Board's Investigation Committee incorporates paragraphs 1 through 13 set out above as its findings of fact.

3. In addition to the other violations contained in the Committee's findings of fact, Respondent's treatment of patient AA on November 4, 2020 is a severe deviation from the applicable standard of care and compelling evidence that Respondent cannot perform tooth extractions without doing unnecessary injury to the patient.

## II. CONCLUSIONS OF LAW AND FACT

For purposes of this order, the Board's Investigation Committee makes the following conclusions of law and fact:

1. Respondent's continued extraction of teeth would constitute an immediate danger to the public health and safety or welfare. The least restrictive way to prevent or avoid that immediate danger is to limit Respondent's License to prohibit him from extracting teeth.

2. There is cause to believe the acts and violations committed by Respondent as detailed in the Committee's findings of fact would form the basis for discipline of Respondent's License, including revocation or suspension, pursuant to various provisions of the Dental Act, including K.S.A. 65-1436 (a)(3), (a)(4) and (a)(17).

## III. EMERGENCY ORDER

Pursuant to K.S.A. 77-536 and K.S.A. 65-1449, and based upon the foregoing findings and conclusions, Respondent's License is hereby limited to prohibit him from performing any tooth extraction until further order of the Board.

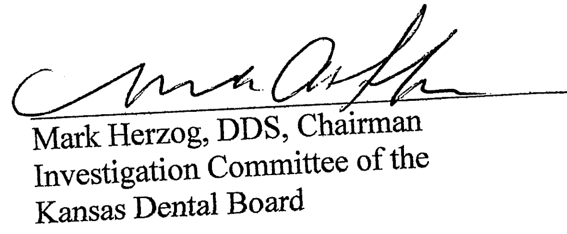
Within fifteen (15) days after service of this Emergency Agency Order, either party may file a petition for reconsideration pursuant to K.S.A. 77-529.

Within the time limits established in K.S.A. 77-613, either party may seek judicial review of this Emergency Agency Order, pursuant to said statute. The agency officer designated to receive service of a petition for judicial review is:

B. Lane Hemsley
Executive Director
Kansas Dental Board
900 SW Jackson, Room 564-S
Topeka, KS 66612

IT IS SO ORDERED.

12/7/20
Date

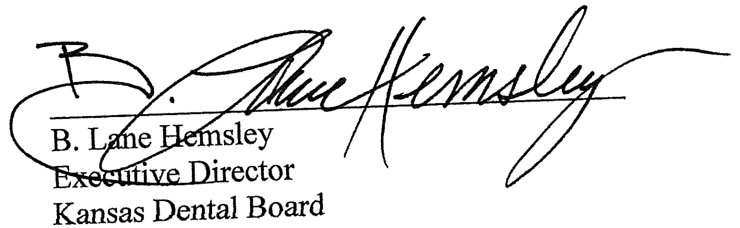


Mark Herzog, DDS, Chairman
Investigation Committee of the
Kansas Dental Board

**CERTIFICATE OF SERVICE**

I hereby certify that I did, on the 14th day of December, 2020, deposit in the United States mail, postage prepaid, a copy of the foregoing EMERGENCY AGENCY ORDER, properly addressed to the following:

Michael Putnam, DDS
1910 SE 29th St.
Topeka, KS 66605



B. Lane Hemsley
Executive Director
Kansas Dental Board