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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **David Reese Rummell, M.D.** 7128 Anjou Creek Circle San Jose, CA 95120 Physician's and Surgeon's Certificate No. G34248, Respondent.	Case No. 800-2019-060856 **A C C U S A T I O N**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On June 20, 1977, the Medical Board issued Physician's and Surgeon's Certificate Number G34248 to David Reese Rummell, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2022, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code provides, in pertinent part, that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes, but is not limited to:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Incompetence)

6. Respondent is an anesthesiologist who, for many years, practiced at a hospital. In September 2019, an anesthesia technician notified one of the staff anesthesiologists that Respondent had a practice of using the same syringe for multiple patients. The staff anesthesiologist took steps to verify the accuracy of the report, then notified hospital medical staff administration. An investigation ensued.

7. During initial interviews with the hospital's quality assurance team, Respondent acknowledged that it had been his practice of many years to use the same syringe on more than one patient. Respondent explained that he reused syringes to avoid waste and expense, and to save time between surgeries. Respondent stated that he changed the needle on the syringe for each patient, but used the same syringe. Respondent posited that the valve system on the intravenous (IV) lines, location of the medication injection point and use of alcohol swabs rendered his practice safe. Several days later, however, Respondent requested a meeting with the hospital investigators. He recanted his earlier admissions, stating that after thinking it over, he

denied it was his usual practice to reuse syringes. Respondent ultimately resigned from his position with the hospital.

8. Respondent was interviewed by the Medical Board's investigators in May 2020. He acknowledged his decades-long practice of reusing syringes on different patients. He reiterated his belief that this practice was acceptable, and recounted that it avoided waste and saved money and time. Respondent stated that he was not aware of any infection transmission resulting from his syringe reuse, a conclusion he based on his practice of following his patients for 24 hours post-operatively via email. When asked about statements made during the hospital inquiry indicating syringe reuse was not his practice, Respondent stated that he was counseled to "muddy the waters" by denying the misconduct.

9. Respondent reused syringes over a period of many years. He continued this practice despite the fact that the hospital where he practiced had a written procedure, initiated in April 2004 and revised as recently as November 2016, clearly stating that medication from the same syringe cannot be administered to multiple patients even if the needle or cannula on the syringe is changed, and despite the common knowledge and understanding among anesthesiologists that this practice was inappropriate, posed a real risk of infection, and was far outside the standard of care.

10. Respondent is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) and/or 2234(d) in that he engaged in unprofessional conduct and/or was grossly negligent and/or committed repeated acts of negligence and/or demonstrated incompetence by virtue of the following:

A. Respondent used the same syringe on more than one patient, thereby exposing patients to an increased risk of infection.

B. Respondent reused syringes on more than one patient despite clear written procedures and well-publicized and well-known standards prohibiting such practice.

C. Respondent demonstrated a lack of knowledge in his belief that bloodborne pathogens from one patient cannot be transmitted to another patient by syringe reuse, even when done with a change of needles, injection to a distal port and use of valved IV tubing. Respondent

also demonstrated a lack of knowledge in his presumption that all infectious processes would reveal themselves within 24 hours of exposure.

D. Respondent made deliberate misrepresentations to the hospital committee investigating his misconduct, for the purpose of benefitting himself, thereby risking compromise of a process designed to promote patient safety.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G34248, issued to David Reese Rummell, M.D.;

2. Revoking, suspending or denying approval of David Reese Rummell, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering David Reese Rummell, M.D. , if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: NOV 25 2020

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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