



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

RE: Randolph B. Bourne, MD
Master Case No.: M2012-398
Document: Statement of Allegations

Regarding your request for information about the above-named practitioner; attached is a true and correct copy of the document on file with the State of Washington, Department of Health, Adjudicative Clerk Office. These records are considered Certified by the Department of Health.

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 Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

FILED
AUG 27 2012
Adjudicative Clerk

In the Matter of the License to Practice
as a Physician and Surgeon of:

RANDOLPH B. BOURNE, MD
License No. MD00047603

Respondent

No. M2012-398

**STATEMENT OF ALLEGATIONS
AND SUMMARY OF EVIDENCE**

The Disciplinary Manager of the Medical Quality Assurance Commission (Commission), on designation by the Commission, makes the allegations below, which are supported by evidence contained in program file number 2011-159469. The patient referred to in this Statement of Allegations and Summary of Evidence is identified in the attached Confidential Schedule.

1. ALLEGATIONS

1.1 On January 29, 2007, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent is board-certified in obstetrics and gynecology. Respondent's license is currently active.

1.2 In October 2008, Patient A was referred by her primary care provider to an obstetrician at Sound Women's Care in Edmonds, WA to rule out an ectopic pregnancy. Initially, Patient A was followed by two of Respondent's partners, who ordered serial pelvic ultrasounds on October 6, 10, and 17, the findings of which indicated that the pregnancy was abnormal and there was a right adnexal mass. A follow-up ultrasound was ordered for October 20, 2008, to confirm the abnormal pregnancy.

1.3 On October 20, 2008, Respondent saw Patient A for the first time to follow up on her problem which resulted in a pre-operative visit. Respondent noted that Patient A was 7 weeks 2 days pregnant, noted serial hCGs to be 32,000, 51,000 and 53,000 respectively, and noted "several ultrasounds" including the "one done today" as showing "nothing in her uterus", "yolk sac is not visible and no embryonic pole is visible, and they should be at this point." Respondent noted additional findings including a cystic structure in the uterus, a large anterior fibroid, a complex cystic mass in the right ovary and a simple cyst in the left adnexa. Respondent concluded that the most likely diagnosis was ectopic

ORIGINAL

pregnancy. Respondent also noted that Patient A did not have any pain at this time and was completely stable. Patient A signed a consent for a D&C and possible laparoscopic salpingectomy or salpingostomy for probable ectopic pregnancy.

1.4 On October 21, 2008, Respondent performed a D&C on Patient A. Respondent determined no evidence of an intrauterine pregnancy and proceeded with laparoscopy. During the laparoscopy, Respondent observed a large right ovarian mass, determined to be a teratoma, which he attempted to remove, leaving the ovary intact. Because of ovarian bleeding, Respondent had to remove the entire right ovary.

1.5 Sometime after the surgery, Respondent received the October 20, 2008, ultrasound report which indicated a uterine pregnancy with a visible yolk sac.

1.6 Respondent's failure to review the October 20, 2008, ultrasound report before taking Patient A to surgery on October 21, 2008, was below the standard of care. Respondent's failure to review the October 20, 2008, ultrasound and convey the contents of the report to Patient A may have denied Patient A the choice of continuing the pregnancy, abnormal or not.

2. SUMMARY OF EVIDENCE

- 2.1 Patient A's medical records.
- 2.2 Respondent's January 12, 2012 response to complaint.
- 2.3 Respondent's March 22, 2012 response to additional questions from the Commission.

3. ALLEGED VIOLATIONS

3.1 The facts alleged in Section 1, if proven, would constitute unprofessional conduct in violation of RCW 18.130.180(4) which provides 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:

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- (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;
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4. NOTICE TO RESPONDENT

4.1 The Commission has determined that this case may be appropriate for resolution through a Stipulation to Informal Disposition pursuant to RCW 18.130.172(2). A proposed Stipulation to Informal Disposition is attached, which contains the disposition the Commission believes is necessary to address the conduct alleged in this Statement of Allegations and Summary of Evidence.

4.2 If Respondent agrees that the disposition imposed by the Stipulation to Informal Disposition is appropriate, Respondent should sign and date the Stipulation to Informal Disposition and return it within fourteen (14) days to the Medical Quality Assurance Commission at PO Box 47866, Olympia, WA 98504-7866.

4.3 If Respondent does not agree that the terms and conditions contained in the Stipulation to Informal Disposition are appropriate, Respondent should contact Karen Caillé, Staff Attorney for the Medical Quality Assurance Commission, PO Box 47866, Olympia, WA 98504-7866, (360) 236-2788 within fourteen (14) days.

4.4 If Respondent does not respond within fourteen (14) days, the Commission will assume Respondent has declined to resolve the allegations by means of a Stipulation to Informal Disposition.

4.5 If Respondent declines to resolve the allegations by means of a Stipulation to Informal Disposition pursuant to RCW 18.130.172(2), the Commission may proceed to formal disciplinary action against Respondent by filing a Statement of Charges, pursuant to RCW 18.130.172(3).

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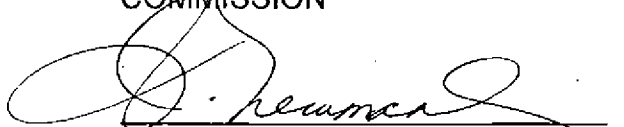
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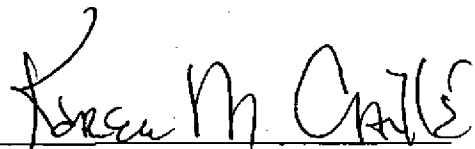
4.6 The cover letter enclosed with this Statement of Allegations and Summary of Evidence was mailed to the name and address currently on file for Respondent's license. Respondent must notify, in writing, the Commission if Respondent's name and/or address changes.

DATED: July 20, 2012.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE
COMMISSION



DANI NEWMAN
DISCIPLINARY MANAGER



KAREN M. CAILLE, WSBA #31351
DEPARTMENT OF HEALTH STAFF ATTORNEY

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

