BEFORE THE

BOARD OF NATUROPATHIC MEDICINE

STATE OF OREGON

In the Matter of the License of:	Case No. 23-07-25
Dr. Jocelyn Cooper, N.D ,	**CONSENT ORDER AND SETTLEMENT AGREEMENT**
Licensee.	

1.

The Board of Naturopathic Medicine (Board) is the state agency responsible for licensing, regulating, and disciplining naturopathic physicians in the State of Oregon, pursuant to Oregon Revised Statutes (ORS) chapter 685 and Oregon Administrative Rules (OAR) chapter 850. Dr. Jocelyn Cooper, N.D. (Licensee) is a licensed naturopathic physician in Oregon and is subject to the jurisdiction of the Board.

2.

The parties wish to resolve this matter informally, without any hearing, appeal or judicial review, by entering this Settlement Agreement and Consent Order, pursuant to ORS 183.417(3) on the terms set forth below. The Board finds the following, which Licensee denies, but stipulates to the terms of the Consent Order:

3.

Licensee first began treating Patient in September 2020. On February 22, 2023, Patient returned for treatment of hyperemesis gravidarum (HG) from a twin pregnancy. Subsequently, Licensee began administering IV rehydration with 1000-2000 ml NaCl to Patient 2-5 days per week.

4.

At / about 8:30am on Monday, June 26, 2023, Patient presented for a scheduled IV rehydration treatment appointment. Clinic IV tech prepared and started an IV on Patient's left arm.

Approximately 20-30 minutes later, Patient reported to the IV tech pain in her left arm. After attempts were made to warm and slow the fluid in the drip, Licensee checked on the patient. Per Patient, Licensee reinserted the IV to the right arm. Licensee removed the IV when Patient told Licensee she felt pain in her right arm. When Licensee removed the IV, she discovered the IV bag contained sterile water. Licensee began a new IV on the right arm with the correct saline solution. When Patient continued to complain of pain, Licensee removed the IV, concluded the treatment and checked Patient's vitals. Serious patient harm, including hemolysis (red blood cells rupture) can result when sterile water is administered by direct IV infusion. Licensee did not tell Patient prior to the patient leaving the clinic that morning Patient was incorrectly injected with sterile water instead of saline. Licensee did not advise Patient to seek emergency care for further evaluation, monitoring and to mitigate potential serious patient harm which can result when sterile water is administered by direct IV infusion.

5.

Licensee sent an email to Patient midday on Monday inquiring how she was feeling. Patient responded stating her urine was brown and asked Licensee if she should be concerned and if she should follow up with her obstetrician. Licensee responded asking Patient to return to the clinic for blood work and urinalysis. When Patient returned to the clinic at / about 4pm the same day to complete the blood and urine samples, patient asked Licensee why her urine was brown. Licensee told patient it was possibly due to dehydration. Potential causes of brown urine are dehydration, hemolysis, and kidney damage, including kidney failure. Licensee did not tell Patient during the follow up conversation or prior to the patient leaving the clinic that afternoon, that Patient was incorrectly injected with sterile water earlier that day. Licensee did not advise Patient to seek emergency care for further evaluation, monitoring and to mitigate potential serious patient harm which can result when sterile water is administered by direct IV infusion.

6.

Licensee reviewed Patient's urinalysis and blood work on Monday afternoon / evening, the tests did not show signs of hemolysis or kidney damage. On Wednesday, June 28, Patient sent an

email to Licensee explaining she was experiencing pain in her inner left arm, from her armpit down toward the IV insertion site. Per Patient, when she returned for scheduled treatment on Thursday, June 28, Licensee looked at Patient's left arm and told patient she had phlebitis. Licensee then administered saline IV treatment to Patient. On Friday, June 30, Patient sent an email to Licensee inquiring about the urinalysis results and told Licensee she was more exhausted than normal. Patient also asked Licensee whether she had any thoughts about why her urine was brown earlier in the week, and why her IV treatment went so differently than previous weeks when she responded well to the fluids. Licensee did not tell Patient during or after her June 28, appointment, or during encounters or communications from Tuesday June 27, through Friday June 30, that Patient was incorrectly injected with sterile water at her appointment on Monday, June 26.

7.

On Friday, June 30, Patient had a chance meeting with a clinic staff member. The staff member inquired how Patient was doing. During the conversation staff member learned Patient did not know she was incorrectly injected with sterile water at her appointment on Monday, June 26. Staff member then told Patient she was incorrectly administered sterile water IV instead of saline during her June 26 treatment. Licensee subsequently met with Patient and her husband to explain what occurred.

8.

On Monday June 26, 2023, Patient was administered approximately 700cc of sterile water instead of saline. Serious patient harm, including hemolysis (red blood cells rupture) can result when sterile water is administered by direct IV infusion. Licensee did not inform Patient of the IV error at the time of her June 26, appointment or during subsequent encounters or communications on that date. Licensee did not advise Patient to seek emergency care for further evaluation or monitoring. This conduct is a violation of 850-050-0010(1)(c)(B): Negligent treatment and 850-050-0010(1)(c)(C): Failure to act in accordance with the American Association of Naturopathic Physicians Code of Ethics as adopted by the Board.

9.

Licensee did not tell Patient during or after her Thursday June 28th appointment, or during encounters or communications from Tuesday June 27, through Friday, June 30, that Patient was incorrectly injected with sterile water at her appointment on Monday, June 26. This conduct is a violation of 850-050-0010(1)(c)(B): Negligent treatment and 850-050-0010(1)(c)(C): Failure to act in accordance with the American Association of Naturopathic Physicians Code of Ethics as adopted by the Board.

10.

The Board finds, and the Licensee denies, the findings of facts and conclusions of law regarding the violations referenced in this settlement agreement and consent order. Licensee agrees that the Board may enter the Consent Order set forth below, including the following terms and conditions:

A. Probation – Two years, with the following conditions:

- CE: Total of 20 hours Board approved continuing education as follows, completed no later than six (6) months from the date of this order.
  - IV policies and procedures,
  - Effective Doctor / Patient Communication – including how to deliver difficult news to a patient
  - Best practices for responding to medical errors.
- Civil Penalty: $10,000, of which $5,000 is abated and will be dismissed upon successful compliance with this order and completion of probation.

B. Licensee shall comply with the statutes, rules and orders of the Board.

C. Licensee's failure to comply with any term of this order, ORS chapter 685 or OAR chapter 850 shall be grounds for additional discipline by the Board.

D. Licensee enters into this Settlement Agreement and Consent Order voluntarily and without any force or duress. Licensee states that the Board and Board staff have not made promises or representations not stated herein to induce her to sign this document and agree to issuance of the Order.

E. Licensee acknowledges that she had the opportunity to seek the advice of legal counsel. Licensee further acknowledges that she understands and agrees to the terms of this Order.

F. Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (ORS Chapter 183), and fully and finally waives any and all right to a hearing and any rights to appeal or otherwise challenge this Settlement Agreement and Consent Order.

G. The parties acknowledge that this Settlement Agreement and Consent Order is a public document.

H. This Settlement Agreement and Consent Order shall take effect on the date it is signed by the Board.

IT IS SO STIPULATED.

Jocelyn Cooper. ND
Jocelyn Cooper. ND (May 30, 2024 13:48 PDT)

Licensee

May 30, 2024
Date

CONSENT ORDER

The Board issues the following order:

A. Probation – Two years, with the following conditions:

- CE: Total of 20 hours Board approved continuing education as follows, completed no later than six (6) months from the date of this order.
  - IV policies and procedures,
  - Effective Doctor / Patient Communication – including how to deliver difficult news to a patient
  - Best practices for responding to medical errors.
- Civil Penalty: $10,000, of which $5,000 is abated and will be dismissed upon successful compliance with this order and completion of probation

DATED this ____30____day of __May_____ 2024.

BOARD OF NATUROPATHIC MEDICINE - State of Oregon

Mary-Beth Baptista, Executive Director