

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

**IN RE: PETER RICHARD COLEMAN, M.D.
 License No.: 0101-037152**

ORDER

In accordance with Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Peter Richard Coleman, M.D. on May 5, 2010, in Henrico, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: Deeni Bassam, M.D. Chairman; Sandra Anderson Bell, M.D.; and Stephen E. Heretick, J.D. Dr. Coleman appeared personally and was represented by legal counsel, Stephen D. Rosenthal, Esquire. Stacy P. Thompson, Adjudication Specialist, was present as a representative for the Administrative Proceedings Division of the Department of Health Professions.

The purpose of the informal conference was to inquire into allegations that Dr. Coleman may have violated certain laws governing the practice of medicine and surgery in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated March 18, 2010.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Now, having properly considered the evidence and statements presented, the Committee makes the following Findings of Fact and Conclusions of Law:

1. Peter Richard Coleman, M.D., was issued license number 0101-037152 by the Board to practice medicine and surgery in the Commonwealth of Virginia on August 9, 1984.

Said license is currently active and will expire on November 30, 2010, unless renewed or otherwise restricted.

2. Dr. Coleman violated Sections 54.1-2915.A(13) and (16) of the Code in his treatment of Patients A, B and C at The Coleman Institute located in Richmond, Virginia. Specifically, Dr. Coleman:

a. Failed to provide for and/or document adequate or appropriate follow-up care and treatment as part of a treatment plan before providing Patient A, a Nevada resident, with rapid benzodiazepine detoxification between on or about September 10, 2008 and on or about September 19, 2008.

b. Failed to provide for and/or document adequate or appropriate follow-up care and treatment as part of a treatment plan before providing Patient B, a Pennsylvania resident with a history of multiple psychiatric problems and a previous suicide attempt, with rapid benzodiazepine detoxification between on or about May 19, 2008 and on or about May 27, 2008.

c. Failed to provide for and/or document adequate or appropriate follow-up care and treatment as part of a treatment plan before providing Patient C, a Kentucky resident, with accelerated detoxification for heroin between on or about December 30, 2007 and on or about January 3, 2008.

3. Dr. Coleman violated Sections 54.1-2915.A(1), (15), (16) and (18) of the Code and 18 VAC 85-20-30(E) of the Board of Medicine General Regulations in that on or about August 12, 2009, Dr. Coleman published or caused to be published on The Coleman Institute's website false, misleading or deceptive statements. Specifically, the website

stated the following: "By using low doses of Flumazenil, patients experience no panic attacks, no insomnia, and no falling apart at the seams. Instead, they are calm and almost peaceful as the benzos are pushed completely out of their systems," despite the fact that those statements were not consistent with the experiences of Patients A or B or with information contained in The Coleman Institute Consent Form for Rapid Benzodiazepine Detoxification.

4. Dr. Coleman explained that when a patient first contacts his office, his intake coordinator ascertains whether the patient is willing to engage in aftercare following detox. All patients who undergo detox are required to arrive with a support person to assist the patient during detox. By the time the patient leaves, the patient is expected to have identified an aftercare program they are going to follow. Dr. Coleman stated that he recently hired an aftercare coordinator who meets with the patient and his or her support person to make sure that the patient has a aftercare treatment program/plan in place. Dr. Coleman stated that the patient is informed that if they do not have a solid aftercare treatment plan in place, they are less likely to be successful.

5. The Committee noted that Patient A had no such support person accompany her for treatment by Dr. Coleman. As a result, one of Dr. Coleman's staff members accompanied the patient to her hotel to act as her support during this process.

6. With respect to Patient A, Dr. Coleman claimed he was clear with her when intake was first done by phone, that she would need intense follow-up due to her psychiatric history and her addiction issues. Dr. Coleman stated that he spoke with Patient A about psychiatric follow-up, but failed to document it. Dr. Coleman provided

the Committee with business cards from Patient A's record, which had not been previously provided to the Board. Dr. Coleman stated that Patient A had provided these cards to show that she had arranged for follow-up care. Upon review, it was noted by the Committee that one of the business cards was from a chiropractor who identified himself as an "*ACACD Certified Addictionologist*;" one was from a naturopathic medical doctor in general practice; and one was from a person who claimed to be a "*Clinical Specialist in Psychiatry*," but who did not have any designating credential to reflect whether she was actually a licensed medical professional.

7. Dr. Coleman stated that after treatment, Patient A was instructed to call him weekly and to see her counselor and/or psychiatrist. Due to Patient A's failure to contact Dr. Coleman, he made subsequent telephone contact with her on three (3) occasions. During the first phone contact on September 29, 2008, Patient A advised Dr. Coleman she had discontinued her medications three (3) days prior. During the second phone contact on October 28, 2008, Patient A reported she was doing well, but that her anxiety was increasing; therefore, Dr. Coleman called-in prescription medications for her to address this issue. During the third phone contact on January 23, 2009, Patient A reported that she was not doing well and not maintaining her recovery program.

8. Dr. Coleman claimed that he advised Patient B that she would need to arrange for aftercare, but this was not documented in Patient B's record. Further, Dr. Coleman stated that due to Patient B's psychiatric history, he took the "additional step" of insisting that she follow-up with her treating psychiatrist.

9. Dr. Coleman explained that Patient C's records were lost in a fire that occurred at his office in April 2008, and so he was unable to provide the original record. Dr. Coleman stated it is his policy to discuss follow-up care with his patients, and pointed out that the record he recreated documented that the patient was doing the things that are usually recommended, for example therapy.

10. The record reflected that Patient C, a Kentucky resident, attempted to seek follow-up care at the Kentucky office location associated with Dr. Coleman's practice, but that office was unable to provide him with an appointment for follow-up care.

11. Dr. Coleman informed the Committee that studies have shown, and he has found in his experience, that the correct, low dose of Flumazenil provides a "partial agonist effect," which alleviates withdrawal symptoms. Dr. Coleman stated his website advertisements were based on this understanding and he did not intend to mislead patients. However, in reviewing his website after the Board investigation, Dr. Coleman has made changes to the statements posted on his website. Dr. Coleman admitted that the website language could have been misleading, but noted that his patient consent forms and the discussions that took place in his office were very clear on the risks and side effects involved in the rapid benzodiazepine detox treatment with Flumazenil.

12. Dr. Coleman stated to the Committee that he prefers to work out the specifics of aftercare when the patient is at his facility and present, and does all he can to get them into ongoing recovery. Dr. Coleman admitted his records had some deficiencies, but attributes those to office circumstances at the time, and states those issues have been addressed.

13. Dr. Coleman stated to the Committee that his medical practice is a "*detox facility, not an addiction treatment center.*" Dr. Coleman stated this he "works very hard" to make sure his patients get follow-up treatment and remain in long-term recovery. He stated that the reality is that he deals with a difficult group of people who are often reluctant to do the work involved in a 12-step program or full recovery.

ORDER

WHEREFORE, based on the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that Peter Richard Coleman, M.D., be imposed MONETARY PENALTY in the amount of five thousand dollars (\$5,000.00). Said monetary penalty shall be paid to the Board within sixty (60) days of entry of this Order.

It is further ORDERED that Dr. Coleman be, and hereby is, issued a REPRIMAND and that his license be subject to the following TERMS AND CONDITIONS:

1. Within sixty (60) days of entry of this Order, Dr. Coleman shall submit a written practice protocol for Board approval, which documents the aftercare plans and follow up providers for all detox patients. The protocol shall include the following aspects.

- a) documented aftercare plan;
- b) patient identified follow-up health care provider(s);
- c) medical release form allowing for communication between Dr. Coleman and the patient's aftercare providers; and
- d) a discharge summary and Dr. Coleman's plan to communicate such information to the patient's follow-up care providers.

2. Within sixty (60) days of entry of this Order, Dr. Coleman shall submit written certification verifying that he has reviewed his entire website to ensure that all information on it provides an accurate reflection of the nature and level of services Dr. Coleman provides, and which are fairly and reasonably available to his patients.

3. Upon verification of Dr. Coleman's compliance with Terms 1 and 2 of this Order, the Committee authorizes the Board's Executive Director to close this matter or refer it to a Special Conference Committee for a final determination.

Violation of this Order may constitute grounds for suspension or revocation of Dr. Coleman's license. In the event that Dr. Coleman violates this Order, an administrative proceeding may be convened to determine whether such action is warranted.

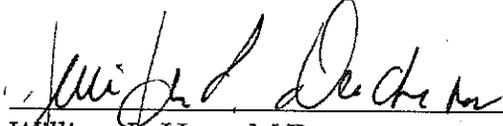
Dr. Coleman shall maintain a course of conduct in his practice of medicine and surgery commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Pursuant to Section 54.1-2400(10) of the Code, Dr. Coleman may, not later than 5:00 p.m., on June 14, 2010, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that he desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

Therefore, this Order shall become final on June 14, 2010, unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

for 
William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 5/12/2010