

STATE OF OHIO  
THE STATE MEDICAL BOARD  
Suite 510  
65 South Front Street  
Columbus, Ohio 43215

October 21, 1982

Freeman B. Webber, M.D.  
19 Hatfield Avenue  
Sidney, New York 13838

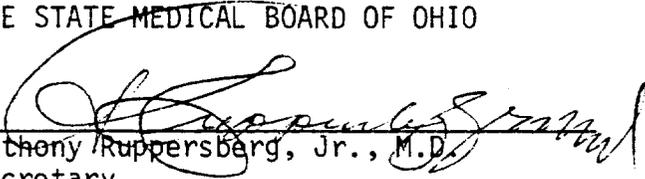
Dear Doctor Webber:

Please find enclosed a certified copy of the Findings, Order and Journal Entry regarding the denial of your application for a license to practice medicine and surgery in the State of Ohio. The Board approved and confirmed said Findings, Order, and Journal Entry, meeting in regular session on October 13, 1982.

You are hereby notified that Section 119.02, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal may be taken to the Court of Common Pleas in the county in which your place of business is located or to said court of the county in which you reside. If you are not a resident of and have no place of business in Ohio, you may appeal to the Court of Common Pleas in Franklin County.

Such an appeal, setting forth the Order appealed from and the grounds of the appeal, must be commenced by the filing of Notice of Appeal with the State Medical Board of Ohio and the appropriate court within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12 of the Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

  
Anthony Ruppertsberg, Jr., M.D.  
Secretary

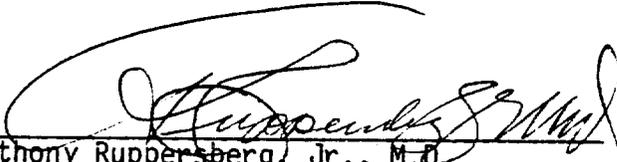
AR:em

CERTIFIED MAIL NO.P32 4765286  
RETURN RECEIPT REQUESTED

STATE OF OHIO  
THE STATE MEDICAL BOARD  
Suite 510  
65 South Front Street  
Columbus, Ohio 43215

CERTIFICATION

I hereby certify that the attached copy of the Findings, Order, and Journal Entry, approved by the State Medical Board, meeting in regular session on October 13, 1982 approving and confirming said Findings, Order, and Journal Entry of the State Medical Board constitute a true and complete copy of Findings, Order, and Journal Entry in the matter of Freeman Webber, M.D., as it appears in the Journal of the State Medical Board of Ohio.

  
\_\_\_\_\_  
Anthony Ruppensberg, Jr., M.D.  
Secretary

(SEAL)

October 21, 1982

\_\_\_\_\_  
Date



STATE OF OHIO  
THE STATE MEDICAL BOARD  
Suite 510  
65 South Front Street  
Columbus, Ohio 43215

July 14, 1982

Freeman B. Webber, M.D.  
19 Hatfield Avenue  
Sidney, New York 13838

Dear Doctor Webber:

In accordance with Chapter 119., Ohio Revised Code, and under authority of Sections 4731.22, 4731.08, and 4731.09, Ohio Revised Code, this is to advise you that the State Medical Board of Ohio hereby proposes to refuse to grant you a certificate to practice medicine in the State of Ohio for one or more of the following reasons:

1. As a result of hearings, on or about March 5, 1980, May 14, 1980, June 11, 1980, July 30, 1980, and September 17, 1980, the New York State Board for Professional Medical Conduct found that you were guilty of practicing the medical profession with gross negligence and/or gross incompetence and that you were guilty of committing unprofessional conduct. The New York State Board for Professional Medical Conduct, in its Report of Findings, Conclusions, and Recommendations dated February 7, 1981, recommended to the Board of Regents that your New York medical license be revoked. Said Report of Findings, Conclusions, and Recommendations is attached hereto and incorporated herein.

On or about March 5, 1981, the New York Commissioner of Health recommended that the Board of Regents accept said Report.

On or about June 12, 1981, the Regents Review Committee recommended that the Board of Regents accept said Report.

On or about June 26, 1981, the Board of Regents accepted the Findings, Conclusions, and Recommendations in said Report and the recommendations of the Regents Review Committee and Commissioner of Health. The Board of Regents then recommended that the Commissioner of Education accept said recommendations and revoke your medical license in New York.

July 14, 1982

On or about July 7, 1981, the Commissioner of Education ordered that your New York medical license be revoked based on the above Recommendations. Said Order is attached hereto and incorporated herein.

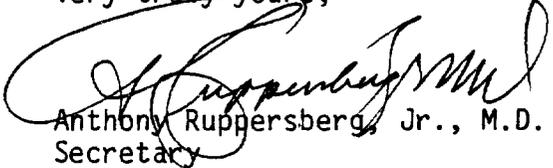
The fact of and bases for the disciplinary action taken against you in the State of New York, are hereby alleged to constitute "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established" which is a ground to refuse to register or otherwise grant you a temporary certificate to practice pursuant to Section 4731.291 and Division (B)(6) of Section 4731.22 of the Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you may request a hearing in this matter. If you wish to request such a hearing, this request must be made within thirty (30) days of the time of mailing of this notice.

You are further advised that you are entitled to appear at such a hearing in person, or by your attorney, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

A copy of the Ohio Medical Practice Act is enclosed for your convenience.

Very truly yours,



Anthony Ruppertsberg, Jr., M.D.  
Secretary

AR:jmb

Enclosures:

CERTIFIED MAIL #P32.4765276  
RETURN RECEIPT REQUESTED

STATE OF NEW YORK : DEPARTMENT OF HEALTH  
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----- X  
IN THE MATTER :  
OF :  
Proceedings by the State Board for Professional : REPORT  
Medical Conduct to determine the action to be : OF  
taken with respect to the revocation or sus- : FINDINGS,  
pension of the license heretofore granted to : CONCLUSIONS  
FREEMAN B. WEBBER, M.D. : AND  
to practice medicine in the State of New York, : RECOMMENDATIONS  
or such other penalty as is warranted; pursuant :  
to Article 2, Title II-A of the Public Health :  
Law of the State of New York. :  
----- X

TO: NEW YORK STATE COMMISSIONER OF HEALTH  
Tower Building, 14th Floor  
Empire State Plaza  
Albany, New York 12237

The undersigned, Hearing Committee on Professional Conduct of the State Board for Professional Medical Conduct, duly designated to hear the charges against FREEMAN B. WEBBER, M.D. hereinafter referred to as Respondent, pursuant to Article 2, Title II-A of the Public Health Law of the State of New York, and to report its findings, conclusions and recommendation in respect to the said charges, do hereby, after due deliberation, unanimously report its findings conclusions and recommendations as provided by law, as follows:

State of New York  
Office of Professional Medical Conduct  
I, \_\_\_\_\_, Director and  
official custodian of the records, do  
hereby certify that this document is a true  
and correct copy of the original on file  
in this office.

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE

RECORD OF PROCEEDINGS

Statement of Charges dated: August 20, 1979

Notice of hearing: Syracuse Airport Inn  
Hancock Airport  
Syracuse, New York

Respondent served with copy of Notice of Hearing and Charges: August 23, 1979

Answer of Respondent verified:  
filed: February 22, 1980

Petitioner appears by ROBERT ABRAMS  
Attorney General of the State of New York

By: Douglas K. McGivney  
Special Designee

Respondent appears in person and by his attorney: Daniel Gorman, Esq.  
22 Riverside Drive  
Binghamton, New York 13905

Respondent's present address: 19 Hatfield Avenue  
Sidney, New York 13838

Hearing (s) held on: March 5, 1980  
May 14, 1980  
June 11, 1980  
July 30, 1980  
September 17, 1980

State of New York  
Office of Professional Medical Conduct  
I, \_\_\_\_\_, Director and  
official custodian of the records, do  
hereby certify that this document is a true  
and correct copy of the original on file  
in this office.

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE

Freeman Webber, M.D.

Freeman B. Webber, M.D. the Respondent herein was issued license #108487 by the New York State Education Department on April 26, 1971, authorizing him to engage in the practice of medicine in the State of New York.

The Respondent is currently registered with the New York State Education Department to practice medicine for the period 1979-1980 from 19 Hatfield Avenue, Sidney, New York 13838.

Respondent was charged under the First Specification of these proceedings with professional misconduct by reason of practicing the profession of medicine with gross incompetence and/or gross negligence on a particular occasion within the purview and meaning of Section 6503, subdivision 2 of the Education Law of the State of New York, in that: During the period from on or about January 25, 1972 through on or about May 19, 1974, Respondent provided treatment to eight patients in a grossly negligent and/or grossly incompetent fashion.

Respondent was further charged under the Second Specification with professional misconduct by reason of committing unprofessional conduct within the purview and meaning of Section 6509, subdivision 9 of the Education Law of the State of New York, in that: (a) On or about May 19, 1974, Respondent failed, and/or refused, without adequate cause to render or arrange for another physician to render necessary medical care to Patient A (the identification of Patient A and all other patients herein is contained in Appendix No. 1 of the Statement of charges herein, Exhibit No. 2) at the emergency room of St. Lukes Memorial Hospital. (b) Respondent was charged with practicing the profession with negligence and/or incompetence on more than one occasion based upon the allegations contained in subparagraph (a) through (h) of the First Specification Paragraph 4 of the Statement of Charges.

Hearings having come on to be heard before us, pursuant to a Notice of Hearing and Statement of Charges on March 5, 1980; May 14, 1980, June 11, 1980;

July 30, 1980; and September 17, 1980, and Respondent having appeared in person and by counsel and a stenographic record having been made of said hearings and the proceedings herein, copies of which are submitted herewith; and documentary evidence having been received including; copies of the constitutional oaths of office signed by the members of the hearing committee; a Notice of Hearing and Statement of Charges; a copy of the Answer and a Demand for a Bill of particulars submitted on behalf of the Respondent; a copy of the subpoena directed to a member of the Gelder Medical Group; a certified copy of the hospital chart concerning Patient C; the curriculum vitae of Henry R. Bartos, M.D., F.A.C.P.; a certified copy of hospital records from The Hospital, Sidney, New York concerning Patient B; a biographical sketch of Doctor Edward A. Swift; a certified copy of hospital records from St Luke's Memorial Hospital concerning Patient A; a copy of an emergency department observation not from St. Luke's Memorial Hospital concerning Patient A; a curriculum vitae for Martin C. Ushkow, M.D.; a certified copy of hospital records from The Hospital, Sidney, New York concerning Patient E; a document entitled Multiple Trauma Patients--Emergency Room, The Hospital, Sidney, New York; a certified copy of the hospital records from The Hospital concerning Patient D; a certified copy of the hospital records from The Hospital concerning Patient D; a certified copy of the hospital records from The Hospital concerning Patient G; a certified copy of the hospital records from The Hospital concerning Patient H; a certified copy of an emergency room record from The Hospital concerning Patient B; a certified copy of an emergency room record from The Hospital concerning Patient C; a document entitled Amendment to Articles of Agreement of Gelder Medical Group Admendment #13 dated December 31, 1972; a copy of a document entitled Application for Appointment to the Medical Staff; a copy of a document from The Hospital relating to Respondent's privileges to practice at

said hospital; and a copy of a letter from Robert W. Bacorn, M.D. to Mr. Milton Jones,

Now, upon deliberation and consideration of the entire record herein, we submit our report, including findings of fact, determination and recommendation, as follows;

Findings of Fact

1. FREEMAN B. WEBBER, the Respondent herein, is duly licensed to practice medicine in the State of New York, having been issued license no. 108484 on or about April 26, 1971, by New York State Education Department.
2. Respondent is currently registered with the New York State Education Department to practice medicine in the State of New York for period 1979-1980 from 19 Hatfield Avenue, Sidney, New York, 13838.
3. We find that the Respondent herein was duly served with a Notice of Hearing and Statement of Charges dated August 20, 1979.
4. We find that Patient B was admitted to The Hospital, Sidney, New York, on January 25, 1972 following an automobile accident. We find that Patient B was suffering from multiple lacerations of the face, scalp and jaw; an open fracture of the left mandible; and extensive internal injuries including a rupture of the right half of the diaphragm with herniation of some of the abdominal contents up into the chest, displacement of approximately 2/3 of the right lobe of the liver into the right thoracic cavity up to the level of the third rib, contusions and hemorrhage of the superior portion of the right lobe of the liver, bilateral rib fractures, collapse of the middle and lower lobes of the right lung as a result of displacement of abdominal structures into the chest, acculumations of blood in both sides of the chest, hemorrhages in the abdomen with acculumations of blood, and trauma in and about the structures of the upper middle portion of the abdomen. We further find that Patient B expired on January 27, 1972 at approximately 4:15 a.m.

as a result of these injuries.

5. We find that the Respondent treated Patient B at The Hospital on January 25, 1972 until her death. We find that Respondent treated the multiple lacerations of Patient B's face, scalp and jaw and wired the open fracture of Patient B's left mandible. We further find that Respondent failed to undertake appropriate and necessary diagnostic measures to discover the nature and extent of Patient B's internal injuries particularly in light of Patient B's continual loss of blood and unstable blood pressure during this hospitalization despite receiving nine units of blood. We further find that Respondent failed to undertake appropriate therapeutic measures in order to treat Patient B's extensive internal injuries including additional blood replacement therapy and surgical treatment. We further find that Respondent failed to obtain appropriate consultations during his treatment of Patient B and failed to transfer Patient B to a larger medical facility better equipped to treat extensive internal injuries.

6. We find that Patient C was admitted to The Hospital, Sidney, New York on March 24, 1972 in a hypermanic state. We find that during this hospitalization, Patient C developed high white blood counts, elevated protein levels in the spinal fluid and elevated body temperature with a fever spike of 103 degrees Fahrenheit on March 30, 1972. We further find that Patient C expired on April 22, 1972.

7. We find that Respondent treated Patient C during his hospitalization. We find that Respondent failed to undertake appropriate diagnostic measures including blood culture studies, urine culture studies, electrolyte studies, chest x-rays, skull x-rays, a brain scan and an electroencephalogram. We find the Respondent failed to make adequate investigations into the possibility that Patient C was afflicted by infection as indicated by his elevated white blood

count and periods of elevated body temperature. We further find that the Respondent failed to make investigations to rule out trauma to the head, metabolic abnormalities, electrolyte abnormalities, cerebral embolus, cerebral thrombosis or thyroid abnormalities as a possible cause of the manic reaction which afflicted Patient C. We further find that Respondent failed to undertake appropriate therapeutic measures including the administration of anti-bacterial drugs to counter any infection which may have afflicted Patient C. We further find that Respondent failed to obtain appropriate consultations from specialists in the field of neurology, ophthalmology, and internal medicine.

8. We find that Patient D, a 72 year old women, was admitted to The Hospital, Sidney, New York on November 13, 1972 for treatment for chronic ulcers of the legs. We find that there was no indication of phlebitis in Patient D's history. We find that Respondent treated Patient D during this hospital admission and performed a right lumbar sympathectomy and a right femoral popliteal bypass using the right saphenous vein on December 28, 1972. We find that subsequent to the bypass surgery, Patient D suffered repeated hemorrhages from the area in her right leg where the vein graft material was obtained. We find that as a result of these repeated hemorrhages Respondent performed an arterial ligation in the right leg to control bleeding. We find that Patient D's right leg subsequently became gangrenous due to inadequate circulation. We find that on January 12, 1973 Respondent performed a low thigh amputation upon Patient D's right leg. We find that Patient D was discharged from The Hospital on February 20, 1973.

9. We find that during the course of his treatment of Patient D Respondent failed to take appropriate diagnostic measures to determine the cause of the ulcers which afflicted Patient D's legs. We find that Respondent failed to obtain angiographic studies of the circulatory system in Patient D's

right leg to determine whether Patient D was actually suffering from any circulatory obstruction or circulatory insufficiency. We find that the right lumbar sympathectomy and the arterial bypass surgery performed by Respondent were not justified and did not constitute an appropriate therapeutic response to Patient D's condition. We find that Respondent failed to obtain appropriate consultation to assist in the effort to determine the cause of Patient D's ulcers. We find that Respondent failed to transfer Patient D to another medical facility where angiographic studies and appropriate treatment could have been undertaken. We further find that Respondent failed to document the cause of Patient D's chronic ulcerations thereby making the hospital record deficient in that respect.

10. We find that Patient E was admitted to The Hospital, Sidney, New York on or about February 22, 1973 suffering from second and third degree burns over 35% to 40% of her body surface involving the hands, face, arms, back, chest, and buttocks together with damage to the lungs, trachea, bronchi, pharynx and mouth due to smoke inhalation. We find that the Respondent treated Patient E during her hospital stay which ended with her demise on March 14, 1973. We find that during this hospitalization, Patient E was placed in a temporary three bed intensive care unit located in The Hospital's solarium which was covered by a single nurse per work shift while having no in unit facilities for the washing of hands. We further find that during this period The Hospital had no respiratory therapy service.

11. We find that during his treatment of Patient E, Respondent failed to undertake appropriate diagnostic measures to determine the exact nature and extent of Patient E's injuries including failing to order serial x-rays of chest and failing to obtain an electrocardiogram after Patient E displayed evidence of tachycardia on February 23, 1973. We find that Respondent failed to obtain appropriate consultation particularly in regard to the areas of

specialized burn treatment and the treatment of infection. We further find that Respondent should have transferred Patient E to a medical facility that was better equipped to treat severe burns than The Hospital, Sidney, New York. We further find that temporary intensive care unit at The Hospital that was in operation during Patient E's hospitalization was not an appropriate facility for the treatment of Patient E's severe burns.

12. We find that all charges relating to the allegations contained in subparagraph (f) of the First Specification, Paragraph 4 herein were withdrawn.

13. We find that Patient G was admitted to The Hospital, Sidney, New York, under a primary diagnosis of obstructive jaundice on April 16, 1973. We find that on April 19, 1973, Respondent performed a cholecystectomy, exploration of the common bile duct, duodenotomy and a transduodenal removal of a calculus in the ampulla of Vater on Patient G. Said procedures were performed by Respondent when Respondent had failed to obtain a prothrombin time prior to conducting surgery. We find that Patient G suffered from persistent post-operative bleeding. We find that Respondent failed to perform or order the performance of follow-up blood coagulation studies to determine whether Patient G suffered from a blood abnormality. We find that Respondent failed to determine whether Patient G was afflicted by a gastric lesion. We further find that Respondent failed to maintain an adequate record of Patient G's treatment by failing to place adequate attending notes in Patient G's hospital chart. We further find that Patient G expired on April 21, 1973.

14. We find that Patient H was admitted to The Hospital, Sidney, New York on August 18, 1973 suffering from multiple injuries incurred in an automobile accident. We find that Respondent treated Patient H during this hospitalization. We find that on August 24, 1973 a follow-up chest x-ray disclosed the possibility of an enlargement of the cardiac shadow indicating

potential fluid accumulation in the pericardial sac. We find that Respondent failed to take appropriate diagnostic measures including additional chest x-rays to determine whether there was progressively increasing tamponade (fluid collection) in Patient H's pericardial sac. We find that Respondent failed to obtain appropriate consultations to evaluate Patient H's condition. We find that Respondent failed to undertake appropriate therapeutic measures to deal with the progressively increasing cardiac tamponade. We find that Respondent failed to transfer Patient H to a larger medical facility better equipped to treat his injuries. We further find that Patient H expired on August 29, 1973 as a result of cardiac tamponade associated with internal and external traumatic injuries.

Determination

We unanimously find and conclude that the charges contained in the First Specification, Paragraph 4, subparagraphs (b), (d), and (h) charging the Respondent with gross negligence and/or gross incompetence, have been proved by substantial Legal evidence and we find the Respondent guilty as charged thereunder.

We unanimously find and conclude that the charges contained in the First Specification, Paragraph 4, subparagraph (g) charging the Respondent with gross negligence and/or gross incompetence have been proved by substantial legal evidence except for the charge that Respondent failed to undertake appropriate therapeutic measures to control the continual massive bleeding which afflicted Patient G. As to all other charges contained in said subparagraph (g) we unanimously find the Respondent guilty as charged.

We unanimously find and conclude that the charges contained in the First Specification, Paragraph 4, subparagraphs (a), (c), and (e) charging the Respondent with gross negligence and/or gross incompetence have not been proved by substantial legal evidence and we find the Respondent not guilty

of said charges. We find and conclude that the charges contained in the First Specification, Paragraph 4, subparagraph (f) were withdrawn.

We find and conclude that the charges contained in the Second Specification, Paragraph 5, subparagraph (a) charging the Respondent with unprofessional conduct have not been proved by substantial legal evidence and we find the Respondent not guilty of said charges.

We unanimously find and conclude that the charges contained in Second Sprcification, Paragraph 5, subparagraph (b) have been proved by substantial legal in so far as said charges relate to the allegations contained in the First Specification, Paragraph 4, subparagraphs (b), (d), (e), and (h) and we find the Respondent guilty of said charges.

We unanimously find and conclude that the charges contained in the Second Specification, Paragraph 5, subparagraph (b) charging the Respondent with unprofessional conduct based upon the allegations contained in the First Specification, Paragraph 4, subparagraphs (c) and (g) have been proved by substantial legal evidence except for the charges in said subparagraph (c) that the Respondent failed to perform a complete physical examination and failed to maintain an adequate record of treatment and except for the charge in said subparagraph (g) that Respondent failed to undertake appropriate therapeutic measures to control the continual massive bleeding which afflicted Patient G. As to all other charges contained in said subparagraphs (c) and (g) we find Respondent guilty as charged.

We unanimously find and conclude that the charges contained in the Second Specification, Paragraph 5, subparagraph (b) charging Respondent with unprofessional conduct insofar as said Specification relates to the allegations contained in First Specification, paragraph 4, subparagraph (a) have not been proved by substantial legal evidence and we find the Respondent not guilty of said charges.

Recommendation

In making our determination, we have considered the entire record herein. We unanimously recommend to the Board of Regents that the Respondent's license to practice medicine in the State of New York be revoked.

Dated: New York, New York  
*Feb. 7<sup>th</sup>*, 1981

Dr. George Hyams, Chairman  
Msgr. Edward Hayes  
Dr. John Spring  
Dr. William Stewart  
Dr. Fremont Peck

*George Hyams M.D.*  
\_\_\_\_\_  
George Hyams, M.D., Chairman

State of New York  
Office of Professional Medical Conduct  
I, \_\_\_\_\_, Director and  
official custodian of the records, do  
hereby certify that this document is a true  
and correct copy of the original on file  
in this office.

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE



The University of the State of New York

IN THE MATTER

OF

Proceedings by the State Board for Professional Medical Conduct to determine the action to be taken with respect to the revocation or suspension of the license heretofore granted to FREEMAN B. WEBBER, M.D. to practice medicine in the State of New York, or such other penalty as is warranted, pursuant to Article 2, Title II-A of the Public Health Law of the State of New York.

No. 2089

Upon the report of the Regents Review Committee, dated June 12, 1931, under Calendar No. 2089, the prior proceedings had herein pursuant to Article 2, Title II-A of the Public Health Law, and the vote of the Board of Regents on June 26, 1931, which report and vote are incorporated herein and made a part hereof, it is

ORDERED that the findings, conclusions, and recommendation of the Hearing Committee on Professional Conduct of the State Board for Professional Medical Conduct as well as the recommendation of the Commissioner of Health with respect thereto, in the matter of FREEMAN B. WEBBER, respondent, be accepted; that the recommendation of the Regents Review Committee be accepted; that respondent is guilty of each specification of the statement of charges to the extent indicated in the report of the Hearing Committee; and that respondent's license and registration to practice as a physician in the State of New York be revoked upon each specification of the statement of charges of which respondent was found guilty, as aforesaid.

IN WITNESS WHEREOF, I, Gordon M. Ambach,

Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany this



7th day of July 1931  
Gordon M. Ambach  
Commissioner of Education

7th 1931  
MEDICAL BOARD  
AM 30 AM 110 92

DATE

6.25.82

SIGNED

*[Handwritten signature]*

State of New York  
Office of Professional Medical Conduct  
I, Kathleen M. Malone, Director and  
official custodian of the records, do  
hereby certify that this document is a true  
and correct copy of the original on file  
in this office.