INTRODUCTION

The University cannot—and will not—tolerate unprofessional, abusive behavior toward nurses, staff, residents, medical students, colleagues or patients that undermines the University of Kentucky’s sense of community. A successful university is a community: a community of collaborative, compassionate people working with a sense of shared purpose toward common goals. The University, as reflected in UK HealthCare’s Behavioral Standards for Patient Care (“Behavioral Standards”), believes in mutual respect and collegiality toward each other and those it serves. Dr. Paul Kearney has made clear, through his words and actions, that he does not share those values.

Moreover, Dr. Kearney’s failure to comply with these behavioral standards and values has real consequences for the University. As the Hearing Panel explicitly found, “personnel in operating rooms . . . tend to employ profanity and other offensive behaviors on a regular basis, to the extent that some witnesses (including Dr. Kearney) claimed that such behavior is simply part of the culture of surgery” at the University. Hearing Panel Recommendation at page 10. The Hearing Panel further indicated its concern about this negative hospital and educational culture:

[T]he evidence presented to the Hearing Panel leaves no doubt that residents and medical students of the University’s College of
Medicine are exposed to the offensive and unacceptable behavior in the course of completing their educational obligations. Even if some of them find this "culture" tolerable (as Dr. Kearney's presentation indicates), no one with responsibility for the education of residents and students of the UK College of Medicine could reasonably believe that this is an acceptable method of preparing students for the practice of medicine. Nothing but a failure to take actions needed to correct this educational shortcoming could ever qualify as unreasonable.

Id. at pages 10-11 (emphasis added). The University must correct this culture. The first step in doing so is permanently removing Dr. Kearney. Just as a doctor must eliminate a tumor before the body can heal, the University must remove Dr. Kearney so it can begin to repair the culture of offensive and inappropriate behavior in the Operating Room that has developed under Dr. Kearney's leadership. As the Hearing Panel concluded, based on decades of efforts to address Dr. Kearney's behavior and an undeniable need for corrective action "...nothing short of the severe sanction that the [Medical Staff Executive Committee] selected could resolve..." this difficult problem. Id., at page 11.

Undoubtedly, Dr. Kearney is a brilliant surgeon, but the practice of medicine is far more than just being highly skilled and clinically knowledgeable. Indeed, as the United States Court of Appeals for the Sixth Circuit, which governs Kentucky, observed earlier this year, "[a]nyone who has ever been to a doctor's office knows the value of a good bedside manner. That is why [the University] does more than just teach its students facts about the human body. Its curriculum identifies nine 'core competencies.' First on the list is professionalism. Medical knowledge does not make an appearance until the fifth slot." Al-Dabagh v. Case Western Reserve University, 777 F.3d 355, 357 (6th Cir. 2015) (affirming a university medical center's denial of a degree for a prospective physician based on his lack of professionalism). Because Dr. Kearney betrays the University's values and has consistently violated the standards of his
profession, his privileges should be permanently revoked. That was precisely the conclusion reached by Dr. Kearney's peers who serve as the UK HealthCare Medical Staff Executive Committee ("MSEC") on February 5, 2015 when, after a careful, thorough and independent investigation and deliberation, they unanimously voted to uphold Dr. Kearney's summary suspension and the related recommendation for revocation of his medical staff privileges. After a two-day hearing and thoughtful deliberation, the Hearing Panel vehemently agreed with the MSEC's decision in its recommendation. For the reasons addressed in this Brief, this Committee should do the same.

SUMMARY OF ARGUMENT

This matter comes before the Committee after decades of Dr. Kearney engaging in demoralizing, unprofessional conduct to his University co-workers and medical students. The University made numerous attempts to respond to and correct his behavior through actions less drastic than the revocation of his privileges at issue here. As will be detailed below, throughout these years, Dr. Kearney's supervisors have had to address a litany of complaints about his behavior including, among others:

- profanity-laced tirades at operating room staff;
- coarse and boorish comments of a sexual nature and otherwise offensive to a number of persons;
- demeaning medical staff personnel with terms such as "bitch", "fucking idiot", "fucking moron" or telling them that they have "shit for brains";
- slapping a member of the nursing staff.

In late 2012, the University offered Dr. Kearney one last chance to correct his unprofessional behavior which culminated in a "last chance agreement" – the terms of which Dr.
Kearney negotiated and signed. Unfortunately, Dr. Kearney continued to engage in conduct that violated both the Behavioral Standards and the terms of his “last chance” agreement, including but not limited to the blatant verbal abuse of a quadriplegic patient in September 2014. In that incident, Dr. Kearney yelled at medical staff during a procedure and used profanity when doing so cursing at the students and directing other derogatory terms to them such as “dumb” and “retarded.” Perhaps even worse, when the patient complained during the medical procedure and requested to be further sedated, Dr. Kearney called the patient a “fucking idiot” (Dr. Kearney denies calling the patient an “idiot” - instead, he admits he called him a “dumbass”).

Despite repeated efforts by the University to correct this behavior in the past leading up to the “last chance agreement”, Dr. Kearney has not changed his behavior, does not want to change and will not change. The University cannot afford the risks that Dr. Kearney’s behavior poses to both proper University culture and sound patient care. As will be discussed and detailed here, the record is replete with support for these conclusions, thus demonstrating that the MSEC’s decision, and the conclusion by the Hearing Panel affirming that decision, was definitively sustained by the evidence; not made arbitrarily, capriciously, or with prejudice; and reached in compliance with the Fair Hearing Plan, so as to provide Dr. Kearney with due process and a fair hearing. Dr. Kearney’s arguments to the contrary are without merit.

**SUMMARY OF PRIOR PROCEEDINGS**

On January 26, 2015, Chief Medical Officer Dr. Bernard Boulanger summarily suspended Dr. Kearney’s clinical privileges pursuant to Article 9.4.1 of the UK HealthCare Medical Staff Bylaws (“Bylaws”) due to unprofessional conduct directed toward staff, resident physicians, medical students, and a patient, in willful violation of the Behavioral Standards.
University Exhibit 5 at pages UK-000029 through 000030. Dr. Boulanger further recommended to the MSEC that Dr. Kearney's medical staff privileges be revoked. See id.

The MSEC, chaired by Dr. Frederick Zachman, met to review and initiate an investigation of those allegations on January 29, 2015. See University Exhibit 6 at pages UK-000032 through 000033. Specifically at issue for the MSEC were several principles and commitments from the Behavioral Standards that Dr. Kearney's behavior potentially violated:

Principle A: Each patient shall be treated as a whole, irreplaceable, unique, and worthy person.

Principle E: Behavior reflecting the dignity, responsibility, and service orientation of health care professionals, worthy of the public's respect and confidence shall be practiced by all individuals.

Commitment: I will recognize that patients and other customers are unique individuals, and I will be sensitive to their life experiences, circumstances and emotions when assessing needs and communicating information.

Commitment: I will use my one opportunity to make an outstanding first impression.

Commitment: I will use language free from obscenities, profanities, and derogatory or abusive remarks.

Commitment: I will value and respect our patients and other customers by honoring their perceptions, preferences and differences.

Commitment: I will be attentive to patients' and customers' thoughts and feelings and adapt my responses to make them feel comfortable and understood regardless of their behavior.

Commitment: I will anticipate and be sensitive to patients and customers with special needs.

Commitment: I will make the customer's safety, health, privacy and welfare my first priority.
Commitment: I will provide expeditious, courteous and flexible service.

Commitment: I will provide positive, professional and prompt responses and keep my facial expressions and tone of voice consistent with my words.

Commitment: I will create an atmosphere of trust and honesty with open communications.

Commitment: I will demonstrate support and respect for my colleagues and handle all interactions in a professional manner.

Commitment: I will demonstrate integrity and professionalism at all times.

Commitment: I will be respectful, talk through issues and conflicts and address conflicts in a respectful way.

Commitment: I will project a positive attitude and keep my work-related or personal frustrations separate from my patient care and professional activities.

See University Exhibit 7 at pages UK-000046 through 000047. By consensus, the MSEC appointed Drs. Susan McDowell and Louis Bezold to conduct an independent investigation. Under the framework of Behavioral Standards set out above, Drs. Bezold and McDowell proceeded with their investigation, reviewing documentation on decades of persistent behavioral problems and interviewing numerous witnesses—including Dr. Kearney—concerning, among other things, a September 2014 patient care incident.

On February 5, 2015, the MSEC reviewed the results of Drs. McDowell and Bezold's investigation and unanimously voted to uphold the summary suspension of Dr. Kearney and the related recommendation that his clinical privileges be revoked. See University Exhibit 8 at pages UK-000089 through 000090. Dr. Kearney invoked his right to a Fair Hearing under the UK HealthCare Medical Staff Bylaws.
On May 27-28, 2015, a hearing was held pursuant to the Article 10 Fair Hearing Plan outlined by the Medical Staff Bylaws. As required under this Article, Dr. Kevin Nelson, Chief Clinical Officer, appointed three members of the UK Medical Staff to serve as the Hearing Panel: Dr. Mark Williams, Dr. Wendy Hanson, and Dr. Lisa Tannock. UK College of Law Professor Robert G. Lawson was appointed to serve as Presiding Officer on this matter. Over the course of a two day hearing, the University and Dr. Kearney were given ample opportunity to present their arguments to the panel, including the introduction of numerous exhibits and testimony of witnesses offered by both parties. The Hearing Panel was also permitted to question the witnesses presented and call their own witnesses so as to obtain a full and clear picture of the matter. After the two-day hearing, examination of many witnesses, and thoughtful deliberation over documentary and testamentary evidence, the Hearing Panel affirmed the MSEC’s decision to uphold the summary suspension and permanent revocation of Dr. Kearney’s medical staff privileges. Hearing Panel Recommendation at page 1. The Hearing Panel issued an eleven page report detailing the reasoning behind its affirmation. See id. at page 4.

The panel aptly indicated that it was tasked under the Bylaws with two questions: “(1) Has Dr. Kearney proved that the recommendation of the [MSEC] calling for revocation of his clinical privileges is not sustained by the evidence? (2) Has he proved that the recommendation, if sustained by evidence, was unreasonable or otherwise unfounded?” Id. If those questions were answered in the negative, then the panel agreed a finding in favor of the MSEC was proper. In fact, according to Rule 10.13.2 of the Medical Staff Bylaws, after the presentation of all evidence for both parties, the Hearing Panel was required to recommend in favor of the MSEC “unless it finds that the Affected Individual has proved that the [MSEC’s] recommendation . . . was unreasonable, not sustained by evidence, or otherwise unfounded.” (emphasis added).
As the written recommendation from the hearing panel details, after careful deliberation, the Hearing Panel affirmed the MSEC’s recommendation to revoke Dr. Kearney’s privileges. Not only did the Hearing Panel find that the MSEC decision was “not unreasonable” in upholding the revocation of Dr. Kearney’s medical staff privileges, the Hearing Panel further stated that “[n]othing but a failure to take actions needed to correct this educational shortcoming could ever qualify as unreasonable.” Hearing Panel Recommendation at page 11 (emphasis added). Based on the evidence, testimony at hearing, and the Hearing Panel’s recommendation, this panel should also affirm the recommendation of the Hearing Panel.

In determining whether the recommendation of revocation of privileges was sustained by the evidence, the Hearing Panel referred to evidence of unprofessional behavior by Dr. Kearney toward a patient, a nurse, and a pattern of unprofessional behavior throughout his career. Hearing Panel Recommendation at page 4. The panel found Dr. Kearney had failed to prove the MSEC’s decision was not sustained by evidence. Id. at page 8. The panel specifically referred to the following evidence to show that the MSEC’s decision was, in fact, supported by evidence:

(1) the most persuasive evidence of the “patient event” was the admission by Dr. Kearney. . . that he called the patient a ‘dumbass,’ his admission that he regularly swears at residents, and the other physicians’ testimony that Dr. Kearney regularly curses directly at them, all of which is reinforced by the spontaneous and unsolicited statements by the patient and his mother, (2) that the most persuasive evidence of the “nurse event” were the unsolicited statements made by nurse [REDACTED] in her letter to the Medical Center legal office, and (3) that the evidence proves beyond all reasonable doubt that Dr. Kearney has been subjected to disciplinary actions and professional counseling for unprofessional behavior on multiple occasions during his career in the Medical Center.

Hearing Panel Recommendation at page 8.
In analyzing whether the second inquiry before it, the Hearing Panel found that Dr. Kearney failed to show the MSEC’s decision was unreasonable or unfounded. Hearing Panel Recommendation at page 11. In so answering, the panel acknowledged Dr. Kearney’s positive qualities as a surgeon and teacher, noting that he is a clinically-excellent surgeon and has received many teaching awards during his career. Id. at pages 8-10. However, the panel also weighed the many negative aspects of his performance. Among these include his extensive documented disciplinary history, with incidents extending as far back as 1992, in which the University repeatedly tried to remediate the unacceptable behavior without success. Id. at page 10. The panel further discussed that a troubling operating room culture has developed under Dr. Kearney’s leadership that must be corrected. Id. Finally, the panel indicated that Dr. Kearney seems unwilling to take responsibility for his unprofessional behavior by consistently minimizing, passing blame for, and outright denying his behavior notwithstanding numerous documented reprimands and corrections over decades. Id. at page 11. The panel rejected allegations of grand conspiracy schemes waged against Dr. Kearney by medical staff administrators because he was unable to produce “more than a shred” of evidence to support him. Id. The panel weighed the severity of imposing sanctions with the seriousness of Dr. Kearney’s unprofessional behavior and found the MSEC was reasonable and well-founded in upholding the revocation of Dr. Kearney’s medical staff privileges concluding the evidence “...strongly supports the Executive Committee’s judgment that nothing short of the severe sanction that it selected [of revocation of clinical privileges] could resolve the difficult problem before it.” Id., at page 11.

After considering these factors, the Hearing Panel found that Dr. Kearney had failed to prove the MSEC’s decision was not sustained by evidence, was unreasonable, or otherwise
unfounded. Therefore, the Hearing Panel correctly found in favor of the MSEC’s decision to uphold the revocation of Dr. Kearney’s medical staff privileges. Dr. Kearney now appeals the recommendation to this Committee.

**STANDARD OF REVIEW**

On review, this Committee’s task is serious but straightforward: Are there grounds to appeal the Hearing Panel’s recommendation affirming the MSEC’s decision? Rule 10.21 of the Bylaws outlines three limited scenarios where an appeal of the Hearing Panel’s recommendation is proper:

10.21.1 There was *substantial failure* on the part of the Hearing Panel [or] the Medical Staff Executive Committee ... *to comply with this Fair Hearing Plan*, so as to deny due process or a fair hearing.

10.21.2 The recommendations of the Hearing Panel ... were made *arbitrarily, capriciously*, or with *prejudice*.

10.21.3 The recommendations of the Hearing Panel ... were *not supported by the evidence*. (emphasis added)

Medical Staff Bylaws 10.21 (emphasis added). Accordingly, absent a substantial failure by the MSEC or Hearing Panel to follow the Fair Hearing Plan; an arbitrary, capricious, or prejudiced recommendation by the Hearing Panel; or a recommendation by the Hearing Panel that was not supported by the evidence, this Committee must affirm the recommendation of the Hearing Panel.

The standard of review for review of the Hearing Panel’s recommendation requiring a decision to be supported by evidence is strikingly similar to standards applied by Kentucky courts when reviewing a state agency decision. One such legal standard asks whether a decision was consistent with the law and supported by substantial evidence. Notwithstanding what the term might suggest, “substantial evidence” simply means evidence that a reasonable mind would
accept as adequate to support it. See Moore v. Assente, 110 S.W.3d 336, 354 (Ky. 2003).
Likewise, Kentucky courts employ a similar standard to determine whether a state agency’s
decision was arbitrary or capricious. A decision is not arbitrary or capricious “[w]hen it is
possible to offer a reasoned explanation, based on the evidence, for a particular outcome.” Davis
v. Kentucky Finance Cos. Retirement Plan, 887 F.2d 689, 693 (6th Cir. 1989). In other words,
these two standards simply require that a decision was based on the evidence presented and
reasonable in light of that evidence.

Additionally, the decisions made by the MSEC and the Hearing Panel must not have been
the result of a substantial failure to follow the Fair Hearing Plan that deprived Dr. Kearney of a
fair hearing or due process. In Article 10, the Medical Staff Bylaws prescribe procedures for a
Fair Hearing Plan. If followed, the Fair Hearing Plan provides the Affected Individual with a
fair hearing and due process. This standard simply requires that the Fair Hearing Plan be
followed without substantial mistakes that would deprive Dr. Kearney of fairness.

In applying these standards, this panel must afford great latitude to the Hearing Panel’s
evaluation of the evidence. The Hearing Panel was entitled to believe some parts and disbelieve
other parts of the evidence before it. Thus, so long as the Hearing Panel’s decision is consistent
with the Behavioral Standards, supported by “substantial evidence,” not made with prejudice
toward Dr. Kearney, and conducted in accord with the Medical Staff Bylaws Fair Hearing Plan,
this panel must uphold that decision even if there is conflicting evidence on the record.

Stated another way, it is irrelevant whether Dr. Kearney agrees with the Behavioral
Standards at issue in this case or their importance to the effective practice of medicine. It also is
irrelevant whether this panel believes it might have reached a different result than the MSEC or
the Hearing Panel. All that matters is that the Hearing Panel’s recommendation to uphold the
MSEC’s decision was supported by meaningful evidence; not arbitrary, capricious, or made with prejudice; and that the MSEC and Hearing Panel followed the Fair Hearing Plan without substantial failure resulting in deprivation of due process or fair hearing. It is up to Dr. Kearney to demonstrate otherwise, but for the following reasons, he cannot.

ARGUMENT

I. Dr. Kearney Has Engaged in Decades of Misconduct

To fully understand the MSEC’s decision to uphold Dr. Kearney’s summary suspension for violation of the Behavioral Standards and the Hearing Panel’s affirmation of that decision, it is important to note Dr. Kearney’s long history of inappropriate workplace behavior. It is clear that the MSEC’s decision was well-supported before it ever came before the Hearing Panel for review. And while Dr. Kearney endeavored to prove otherwise, the evidence presented to the Hearing Panel—including the testimony of residents called by Dr. Kearney and witnesses who appeared at the Hearing Panel’s request—only reinforced why the Hearing Panel’s decision must be upheld.

The apex of Dr. Kearney’s unprofessional conduct came in September 2014 when he went beyond prior practices of berating those he worked with and actually engaged in the verbal abuse of a quadriplegic patient named [REDACTED]. The significance of the problem, however, cannot be duly appreciated without first reviewing the persistent pattern of malignant behavior that preceded it—behavior that Dr. Kearney repeatedly failed to correct despite the support of his colleagues and a critical shift in the culture of modern patient care.

A. 1992

From 1992 through at least 2005, Dr. Kearney engaged in a series of documented events involving unprofessional and inappropriate behavior, all of which Dr. Kearney concedes he was
aware. The first such documented event was in March 1992, when Dr. Kearney was corrected for engaging in “rude, offensive, impolite, arrogant and loud” behavior toward an office staff member. See University Exhibit 7 at pages UK-000035 and UK-000048.

B. 1995

In July 1995, Dr. Kearney was corrected because he “publicly announced on patient care rounds that a patient’s deterioration was due to OB not delivering the patient early enough and because the OB attending was too lazy to get up in the middle of the night.” See University Exhibit 7 at pages UK-000035 and UK-000049 through 000050.

C. 2000

In August 2000, several operating room (“OR”) nurses wrote letters about an incident in which Dr. Kearney engaged in a “crude, unprofessional, loud, disruptive, inappropriate, unwelcome, unwarranted, vile, offensive, inexcusable, discomopassionate [sic] verbal exchange that compromised the nurses’ ability to provide patient care.” See University Exhibit 7 at pages UK-000035 and UK-000050 through 000056. In September 2000, former Chair of Surgery Dr. Byron Young addressed these matters with Dr. Kearney, offered voluntary remediation regarding that conduct and advised Dr. Kearney that failure to meet the terms of remediation could result in corrective action including termination of medical staff privileges. See University Exhibit 7 at pages UK-000035 and UK-000058 through 000059.

D. 2005

In July 2005, former Dean of the College of Medicine Dr. Jay Perman wrote Dr. Kearney asking for a meeting to discuss a “profanity laced, totally uncalled for, outburst” during the care of a trauma patient the preceding month. Dr. Perman warned Dr. Kearney that he would have
zero tolerance for “continued inappropriate behavior on your part which demeans the entire institution.” See University Exhibit 7 at pages UK-000035 and UK-000060.

E. 2009

Dr. Kearney’s behavior persisted to the point that it drove long-time friends and colleagues like Chief Nursing Executive Colleen Swartz and Chief of General Surgery Dr. Patrick McGrath, together with Surgery Department Chairman Dr. Jay Zwischenberger and former Chief Medical Officer Dr. Paul DePriest, to send a letter dated January 7, 2009 to their superiors at UK HealthCare. See University Exhibit 7 at pages UK-000035 through 000036 and UK-000061. The group’s letter stemmed from complaints by medical students, residents, nurses, colleagues and others, and multiple attempts to get Dr. Kearney to alter his behavior without success. See testimony of Dr. Zwischenberger, Hearing Transcript Vol. 1 at page 191. The letter advised:

In recent months, Dr. Paul Kearney has continued to exhibit aggressive and humiliating behavior around colleagues and staff. There have been numerous complaints which are serious and which require management of intervention. In addition, his attitude toward colleagues is perceived as derogatory and impacts on student education . . . [W]e believe that without identifiable intervention, Dr. Kearney and UK HealthCare are at risk (emphasis added).

University Exhibit 7 at page UK-000061 (emphasis added). Dr. Kearney has indicated this letter may have been written close in time to a personal tragedy in 2009, or that the date of the letter may actually be off by a year (2010). See testimony of Dr. Kearney, Hearing Transcript Vol. 2 at pages 128-129 and 289-291. Nevertheless, it is clear that his behavior had become serious enough to prompt his colleagues and friends to seek funding from the University so Dr. Kearney could obtain “identifiable intervention.” See University Exhibit 7 at page UK-000061. Indeed, according to Dr. Zwischenberger, the request was prompted by a “cumulation of issues” and an
"inability to effect change." See hearing testimony of Dr. Zwischenberger, Hearing Transcript Vol. 1 at page 192. In other words, the problem was not one of random, isolated events, but rather, of a "chronic, constant method of behavior" that Dr. Kearney had repeatedly either failed or refused to control. Id. at page 222.

F. 2012

Unfortunately, Dr. Kearney's behavior did not improve in the years that followed, and if anything, it worsened. In 2012, three serious complaints from nurses arose that the University could not ignore.

In September 2012, Dr. Kearney smacked nurse [redacted] on the shoulder because she had "messed up a timeout." When [redacted] advised Dr. Kearney that she was pregnant, Dr. Kearney told her, "Whose fault is that, yours or the guy? I guess it doesn't matter because it takes two to tango." While Dr. Kearney denied slapping [redacted], he admitted to the comments she alleged and offered similar admissions during his testimony before the Hearing Panel, conceding that he at least said, "Well I hope you know how that [pregnancy] happened." See testimony of Dr. Boulanger, Hearing Transcript Vol. 1 at page 165; testimony of Dr. Kearney, Hearing Transcript Vol. 2 at page 139; University Exhibit 7 at page UK-000073.

In May 2012, Dr. Kearney said "Hey bitch" to [redacted] when she stepped up to the operating table. When confronted about it then, and when questioned about it again at hearing, Dr. Kearney advised he did not specifically remember making the comment but also did not deny it. See testimony of Dr. Boulanger, Hearing Transcript Vol. 1 at page 166; testimony of Dr. Kearney, Hearing Transcript Vol. 2 at page 152; and University Exhibit 7 at page UK-000074.

Perhaps most concerning for reasons discussed further below, that same year Dr. Kearney responded to [redacted]'s failure to act as quickly as he had wanted by confronting her at...
the control desk in front of two employees and telling her, “You should have a colostomy bag over your head. You have shit for brains.” See University Exhibit 7 at page UK-00074. Again, Dr. Kearney admitted to this remark when confronted about it at the time and again when he testified at hearing. See testimony of Dr. Boulanger, Hearing Transcript Vol. 1 at pages 165-166; testimony of Dr. Kearney, Hearing Transcript Vol. 2 at page 142; and University Exhibit 7 at page UK-000074.

This series of incidents led to a “last chance” agreement, discussed in further detail below, designed to give Dr. Kearney one final opportunity to correct his behavior. However, as demonstrated by subsequent events, that agreement did not have its intended effect.

G. 2014

1. Student lecture

In August 2014, the University received a student complaint about a lecture Dr. Kearney gave. Although at hearing in this matter Dr. Kearney proudly testified he received applause for this lecture, not all students in attendance were so moved as evidenced by this complaint. In his lecture, Dr. Kearney made numerous derogatory remarks, including the following:

a. Dr. Kearney told a student who was auditing the class that he looked “about 50” and was old enough to be the parent of other students in the class.

b. After watching a video of a woman falling off a motorcycle, Dr. Kearney told the class that the lesson to be learned from that video was that “fat chicks shouldn’t ride motorcycles.”

c. In response to a student’s answer to a question, Dr. Kearney remarked that “Asians always know the answer.”
d. When discussing how national operations in the post-World War II era influence life today, Dr. Kearney stated that we “don’t bomb Japs and Germans” anymore.

e. Dr. Kearney asked, “Who gets thoracic outlet syndrome? Ladies?” and then stated that the answer was “large pendulous breasts.”

f. In contrasting gastroschisis and omphalocele, Dr. Kearney suggested that children born with the latter defect are “freaks.”

See University Exhibit 7 at pages UK-000079 through UK-000082. Upon receiving the student complaint about this lecture, the University’s Senior Associate Dean for Medical Education, Dr. Charles Griffith, reviewed a recording of it and reported his findings to Dean of Medicine Dr. Fredrick de Beer. See id. In turn, Dr. de Beer removed Dr. Kearney from teaching that particular class, as is well within the Dean of Medicine’s discretion to do. See Testimony of Iler, Hearing Transcript Vol. 2 at pages 283-284.¹

2. [Redacted] was a clinical nurse employed at the University from March 10, 2014 through August 26, 2014, prior to Dr. Kearney’s paid administrative leave that took effect in September 2014. In October and November 2014, [Redacted] complained to the University about a hostile environment created by “verbal, emotional, and physical abuse” from Dr. Kearney. See University Exhibit 7 at pages UK-000083 through 000086. By way of example, [Redacted] recounted an incident in which a bipolar machine was not operating correctly because, as it turned out, a

¹ Dr. Kearney’s removal from the classroom was not at issue in this hearing. His underlying behavior, however, is squarely contrary to the Behavioral Standards and indicative of the persistent pattern of unprofessional conduct that Dr. Kearney has engaged in since signing his “last chance” agreement in 2012, discussed further below.
resident had his foot on the wrong pedal. *See id.* at page UK-000084. Kearney, however, blamed [redacted] for the error, calling her a “fucking idiot” and a “fucking moron.” *See id.* Kearney sought at hearing to discredit [redacted]’s motives and at first argued he would not have called [redacted] a “fucking moron”—but then quickly revised his position and contended simply that he would not have done so in a “derogatory, hateful way.” Testimony of Dr. Kearney, Hearing Transcript Vol. 2 at page 155.

3. [redacted]

The events of Fall 2014 brought about much more than staff and student complaints. In September 2014, Dr. Kearney extended his verbal abuse beyond the circle of those he worked with and directed it at [redacted] a quadriplegic patient in the operating room during a [redacted] that involved some complications with students and residents handling the procedure under Dr. Kearney’s supervision. Dr. Boulanger testified, and the evidence before both the MSEC and the Hearing Panel confirms, that [redacted]’s recollection of events about the procedure and Dr. Kearney’s behavior was credible, with recall of fine details about the operating room, equipment used during the procedure like a green bite block, ongoing activity in the room such as a male employee trying to make an incision in his abdominal wall, trouble with insertion of the [redacted] and replacement of personnel in the room. *See* testimony of Dr. McDowell, Hearing Transcript Vol. 1 at page 106; testimony of Dr. Boulanger, Hearing Transcript Vol. 1 at pages 174-175. More specifically, though, and of great concern, [redacted] heard Dr. Kearney direct several profane and derogatory comments around and even at him during the procedure, which [redacted] shared with MSEC investigators in February 2015. [redacted]’s testimony to the MSEC investigators was consistent with his prior interview with Dr. Boulanger in Fall 2014, and included the following:
• Dr. Kearney told someone, "Pry his fucking mouth open."

• Dr. Kearney told [redacted] "We do not put you to sleep for this, you fucking idiot."

• Dr. Kearney told a resident to "make the fucking incision."

See University Exhibit 7 at pages UK-000042 through 000043; September 11, 2014 report to Dr. Bernard Boulanger on [redacted] Investigation at page 2. Also told Dr. McDowell that he heard Kearney tell someone, "He cannot feel it. He is a fucking quad." See University Exhibit 7 at page UK-000043.

[redacted]'s memories and allegations were corroborated by multiple witnesses, almost all of whom were interviewed by Drs. McDowell and Bezold on behalf of the MSEC. Resident (and witness on behalf of Dr. Kearney) Dr. Ross Strong, conceded at hearing that, consistent with [redacted]'s recollection, restraints were used during the Testimony of Dr. Strong, Hearing Transcript Vol. 1 at pages 251-252. Medical student [redacted] told Drs. McDowell and Bezold that Dr. Kearney was cursing at residents during the procedure. Testimony of Dr. McDowell, Hearing Transcript Vol. 1 at page 110. Endoscopy equipment specialist Caitlyn Rice told Drs. McDowell and Bezold that a green bite block was used during the procedure, that [redacted] was awake for most of the procedure, that Dr. Kearney was yelling at residents and calling them names like "dumb" and "retarded" during the procedure, and that Dr. Kearney said "stuff to the patient that was very unprofessional and included profanity." See University Exhibit 7 at pages UK-000040 through 000041. A resident, Dr. Justin Peterson, recalled a lot of cussing and name calling throughout the procedure. See id. at pages UK-000041 through 000042. As part of the MSEC investigation, Dr. Peterson further told Drs. McDowell and Bezold that Dr. Kearney responded to [redacted] with a derogatory term when [redacted] asked to be put to sleep. See id. And while Dr. Peterson was hesitant to use explicit language with Dr.
McDowell, who is the Associate Dean of Graduate Medical Education, he was clear about what was said in his Fall 2014 interview with the Office of Legal Counsel, noting that Dr. Kearney told \[\text{redacted}\] “We don’t put people to sleep for things like this you fucking idiot.” See id.; see also September 11, 2014 report to Dr. Bernard Boulanger on \[\text{redacted}\] Investigation at page 5.

Even Dr. Kearney has admitted to behavior during \[\text{redacted}\]’s procedure that clearly violated the terms of his 2012 “last chance” agreement and the Behavioral Standards at issue in this case. When interviewed by Drs. McDowell and Bezold, Dr. Kearney admitted he could “almost guarantee I used profanity,” that he “likely yelled,” and that he did at least call \[\text{redacted}\] a “dumb ass” in the operating room. See University Exhibit 7 at pages UK-000043 through 000044. Similarly, Dr. Kearney testified to the Hearing Panel that he called \[\text{redacted}\] a “dumb ass” and, as for his treatment of residents in the operating room: “Now was I yelling at the residents? Not yelling. Was I using names on them? You bet.” Testimony of Dr. Kearney, Hearing Transcript Vol. 2 at page 93 (emphasis added).

These facts and testimony recounted above are serious—and cause for serious concern. Dr. Kearney’s inappropriate and unacceptable behavior is not isolated to a few instances in 2014 but spans decades. The corroborated testimony, the record and the admissions of Dr. Kearney overwhelmingly confirm that the Hearing Panel’s affirmation of the MSEC’s decision was indeed sustained by the evidence.

II. Dr. Kearney’s Behavior Has Serious Consequences

The gravity of Dr. Kearney’s verbal abuse of \[\text{redacted}\] is defined not only by the incident itself but, moreover, by the framework of Dr. Kearney’s past behavior, the risks to patient well-being created by such behavior, the standards Dr. Kearney pledged to uphold and the terms of his 2012 “last chance” agreement, discussed below, which clearly establish he
already has exhausted all reasonable chances to correct his conduct. Indeed, Dr. Kearney’s behavior and the MSEC’s and Hearing Panel’s corresponding decisions must be examined, not through the litany of finger-pointing and excuses Dr. Kearney has offered, but by the standards and conditions Dr. Kearney promised to follow. See University Exhibit 7 at pages UK-00045 through 000047 and University Exhibit 1 at pages UK-000001 though 000002. Measured by those standards and conditions as applied to the evidence of record, the Hearing Panel’s decision is fundamentally reasonable and well-founded.

A. **Dr. Kearney’s Behavior Creates An Unacceptable Culture And Puts Patients At Risk**

Leaders like Dr. Kearney must teach by example. While his clinical oversight may have built a recognized Level I trauma center, the University must be concerned in considering the house Dr. Kearney has built and precisely what type of physicians of the future he has helped to create. Unfortunately, Dr. Kearney’s example has produced disturbing results. Dr. Kearney proudly testified at hearing about the standing ovation students gave him after he delivered the aforementioned lecture in 2014 that, as Dr. Kearney conveniently overlooked, included derogatory remarks about age, “fat chicks,” Asians, “large pendulous breasts,” “Japs,” children with birth defects whom he referred to as “freaks,” and more. See University Exhibit 7 at pages UK-000079 through UK-000082.

Moreover, some residents who have trained under Dr. Kearney have demonstrated a level of comfort with and even admiration for Dr. Kearney’s behavior. Dr. Strong testified at hearing that he might call a patient a “dumb ass” in the future, “depending on the relationship.” Testimony of Dr. Strong, Hearing Transcript Vol. 1 at page 256. Dr. James Lynch testified he does not find raising voices or cussing at staff in a demeaning or humiliating way to be offensive. Testimony of Dr. Lynch, Hearing Transcript Vol. 1 at pages 331-332. Dr. Lynch also admitted
that in the future he might even greet a nurse by saying, "hey bitch." See id. at page 333. Dr. Lynch even suggested it might be appropriate to tell a nurse she should wear a colostomy bag over her head because she has "shit for brains." See id. at pages 333-334. As Dr. Lynch explained, that remark is used by "numerous surgeons in the OR" to the point where it has become "kind of an inside surgical joke." See id. at page 336. Dr. Lynch apparently knows that such a remark is "immature" and admits it sounds berating, but at the same time he still thinks the remark is "kind of witty." See id. at pages 336-337. After all, Dr. Lynch testified, "It's the culture. I think that's the culture...It's a culture we have here at UK." See id. at page 336.

Of course, this is not the culture promoted by the University's Behavioral Standards, but sadly it does appear to be the "culture" that has developed within the trauma program that "Dr. Kearney built." Moreover, it is a culture of behavior that goes well beyond acts of merely cursing in frustration in a high-stress environment to which Dr. Kearney would like to be compared. Indeed, Dr. Kearney's conduct is materially distinct from the general "venting" that he argues is acceptable or at least excusable.

Colleen Swartz is responsible for oversight of nursing practice across the University, has worked with Dr. Kearney since he arrived at the University and signed off on the 2009 request for intervention discussed above. Swartz testified that Dr. Kearney uses profanity in dealing with staff, and that it is more than just cursing around them: it is targeted and intentionally embarrassing to staff whom Dr. Kearney is upset with, fueled by Dr. Kearney's aptitude and propensity for identifying and exploiting the sensitivities and insecurities of others. Testimony of Swartz, Hearing Transcript Vol. 1 at page 216. As stated another way by Dr. Zwischenberger: "Paul had a way of cussing directly at people and making them feel personally responsible for whatever was happening in terms of patient outcomes or care or complications or difficult
situations. He would *personalize it.*” Testimony of Dr. Zwischenberger, Hearing Transcript Vol. 2 at page 197 (emphasis added).

The distinction between Dr. Kearney’s behavior versus normal expressions of frustration is one that Dr. Kearney’s own colleagues—indeed, his own witnesses—easily recognize. As Dr. Rolando Berger explained at hearing:

Well, you know, if it is using the language to address individuals and people directly to them, no, I never do. So I will never call somebody a name or describe somebody or argue with somebody subordinate, superior or equal, patient, family and talk to them... But again, as I said, not directly to a person or an individual or whatever, but just as an expression, like when you say the F-word when you hit your thumb with a hammer, it’s just—you’re not calling anybody anything. You just hit your finger and you do that. That’s very common...

[W]hen it’s done in anger and with an intention to insult and demean, no, I don’t consider that acceptable.

Testimony of Dr. Berger, Hearing Transcript Vol. 2 at pages 56, 58, 62 and 63. For those reasons, Dr. Berger stated “I would *not* use language directly to insult or attack a person...I would *not* use language to attack a person.” *Id.* at page 62 (emphasis added).

B. **Dr. Kearney’s Behavior Violates ACGME Core Competencies and Other Key Standards**

The reasonableness and sound footing of the Hearing Panel’s affirmation of the MSEC’s decision is underscored by the educational standards by which faculty—including Dr. Kearney—are expected to train and measure students and residents. *See* University Exhibit 12 at pages UK-000161 and UK-000165. In addition to investigating this case on behalf of the MSEC, Dr. Susan McDowell serves as the Associate Dean for Graduate Medical Education and as the University’s Designated Institutional Official for ACGME issues. *See* testimony of Dr. McDowell, Hearing Transcript Vol. 1 at pages 73-74. As Dr. McDowell explained, the ACGME
has developed six “core competencies” for physicians in training, which include interpersonal communication skills and, notably, professionalism. See id. at pages 74-75. These core competencies reflect the principles contained in the University’s Behavioral Standards and provide common requirements for all physician training programs at the University. Testimony of Dr. McDowell, Hearing Transcript Vol. 1 at pages 74-75 and 120. The professionalism competency includes the ability of a health care provider to interact with others in a professional, respectful and courteous manner. Id. at page 75.

The ACGME’s core competencies and the University’s Behavioral Standards mark a critical shift in thinking from several years ago as to what it means to be a good physician. See testimony of Dr. McDowell, Hearing Transcript Vol. 1 at page 120. The colleagues who provide patient care alongside Dr. Kearney recognize and understand this importance. Dr. Boulanger testified, “We don’t want a physician who verbally abuses patients and verbally abuses staff, medical students, and residents.” Testimony of Dr. Boulanger, Hearing Transcript Vol. 1 at page 206. Dr. McDowell testified that behavior like telling a nurse she should “put a colostomy bag over your head because you have shit for brains” would be inappropriate. Testimony of Dr. McDowell, Hearing Transcript Vol. 1 at page 121.

Witnesses who testified on Dr. Kearney’s behalf also understand how things have evolved in the measurement of a good physician. Jessica Johnston, a nurse who testified on Dr. Kearney’s behalf, stated she does not think it is appropriate to call someone an idiot or moron. Testimony of Johnston, Hearing Transcript Vol. 2 at page 70. Patient Care Manager admitted that Dr. Kearney’s cursing is outside the bounds of what is considered professional. Testimony of, Hearing Transcript Vol. 1 at page 304. Even Dr. Kearney, at least on some superficial level, understands his behavior is unacceptable, conceding at hearing that the remarks
he has admitted to—and there are several—violate the University’s Behavioral Standards for Patient Care. Testimony of Dr. Kearney, Hearing Transcript Vol. 2 at page 157.

In truth, no reasonable physician can argue that Dr. Kearney’s persistent verbal abuse is consistent with or conducive to the provision of patient care today. As Dr. Zwischenberger explained:

And we have a culture of surgical resident and students that actually like it [Kearney’s behavior]. They think it’s macho and they really—they respond well to it. And back in the day, when many of us were trained, including Paul, that was the norm.

But as training situations and cultures evolved...In fact, as time has evolved, nurses, students, residents, coworkers tend to be so offended by that type of behavior that they don’t perform well or they shut down or they can’t perform their duties...and I can say that the last ten years that that pendulum has swung rapidly.

Testimony of Dr. Zwischenberger, Hearing Transcript Vol. 2 at pages 197-198. Dr. Kearney may believe that Dr. Zwischenberger is “out of touch.” However, Dr. Kearney fails to recognize that his refusal to adapt his behavior to the 21st Century is plainly “out of touch” with the mission of the University to train and equip physicians to serve the healthcare needs of the Commonwealth and beyond.

C. Dr. Kearney Refuses to Alter His Behavior

1. Dr. Kearney was Given One Last Chance

The previously-discussed series of incidents in 2012 led to an investigation by the University Office of Legal Counsel and a “last chance” agreement between Dr. Zwischenberger and Dr. Kearney. See University Exhibit 1 at pages UK-000001 through 000003. The seriousness of the situation was discussed with Dr. Kearney prior to execution of the agreement. As Dr. Boulanger explained, “I remember the discussion we had in December of that year before the agreement was signed, and there was—it was shared with Dr. Kearney that he needs to
change because he's putting the university at risk.” Testimony of Dr. Boulanger, Hearing Transcript Vol. 1 at page 168. Thereafter, Dr. Kearney then negotiated the agreement’s terms with the Office of Legal Counsel and signed it on January 9, 2013, providing in relevant part:

In the future, you shall refrain from such unprofessional conduct with interacting with other UK personnel...In addition, you shall not direct profane comments toward UK personnel if, in your opinion, they fail to perform their duties adequately...If a physician, nurse, tech, or other personnel fails to perform his or her job in a manner that is unsatisfactory to you, you shall address all performance issues in a professional manner, either directly with the employee or the employee’s supervisor... 

If you violate any of the terms of this action plan, you will be subject to corrective action.

Testimony of Iler, Hearing Transcript Vol. 2 at pages 159 and 265-267; University Exhibit 1 at pages UK-000001 through 000003. As Dr. Boulanger, who was involved in the process, explained:

The hope was that once the agreement was signed and agreed to by Dr. Kearney that we wouldn’t hear anymore about Dr. Kearney except for, you know, the many positive things that he’s, you know, been able to do as a physician.

Testimony of Dr. Boulanger, Hearing Transcript Vol. 1 at page 168 (emphasis added). Dr. Kearney has thus already had his last chance, and the record shows that extending yet another “last chance” offers no prospects for change.

2. Dr. Kearney Will Not Change

Unfortunately, it is quite clear that Dr. Kearney repeatedly has and will continue to use profane and abusive language to attack and humiliate other members of the University healthcare community. Dr. Strong testified that Dr. Kearney addresses his profanity at staff members and residents, and Julie Hudson explained that the complaints she has received about Dr. Kearney concern behavior actually directed toward, rather than merely expressed around, her staff.
Dr. Kearney fails to understand or at the very least severely underappreciates the impact of his behavior on patient care. To Dr. Kearney, the question of patient care impact is merely a “mantra” used by the University to advocate his dismissal. To the MSEC, the Hearing Panel, and other colleagues, though, the risk of Kearney’s behavior is very real. As Dr. McDowell testified at hearing, literature shows that the failure to exercise professionalism and good interpersonal communication actually decreases the likelihood of patient satisfaction while increasing the likelihood of staff turnover, the risk of medical error and adverse patient events. Testimony of Dr. McDowell, Hearing Transcript Vol. 1 at page 119. More specifically, unprofessional behavior such as telling a nurse she should wear a colostomy bag over her head because she has “shit for brains” limits and can even block that person’s ability to speak up when needed in order to prevent an adverse patient event. See id. at page 121. As Colleen Swartz explained, the berating behavior for which Dr. Kearney is known “can become a distraction...creating an environment where the staff are doing everything they can to stay unnoticed, and sometimes that activity takes precedence over focusing on clinical care of patients.” Testimony of Swartz, Hearing Transcript Vol. 1 at page 217 (emphasis added). More succinctly, as Julie Hudson testified, attacking and humiliating nurses like Dr. Kearney does “sucks the smarts right out of [them].” Testimony of Hudson, Hearing Transcript Vol. 2 at page 187 (emphasis added).

The University has repeatedly tried to steer Dr. Kearney in the right direction, but to no avail. Dr. Kearney’s behavior is not merely sporadic or incidental, and contrary to what Dr. Kearney contends, it is by no means limited to the series of write-ups that appear in his file.
Rather, it is “Recalcitrant and unprofessional behavior that over the years was unable to be impacted or remediated, his outright violation of the medical staff bylaws, including the UK HealthCare behavioral standards, and very importantly the violation of the written reprimand that he signed in January 2014.” Testimony of Dr. Boulanger, Hearing Transcript Vol. 1 at page 184.

As Dr. Zwischenberger thus explained at hearing about his experience with Dr. Kearney since becoming Chair of Surgery in 2007:

They—so to answer [Dr. Tannock’s] question, [complaints] came from everywhere. They came from staff. They came from nurses. They came from anesthesiologists. They came from colleagues, residents, students. They were so commonplace that I didn’t actually keep track of them on a specific one-to-one basis. It was a trend of behavior that was across the board, and that’s what we were trying to counsel. That’s what we were trying to change. And that’s what Dr. DePriest and McGrath and me and others wore ourselves out trying to effect behavior change.

It wasn’t a single incident of hitting one person and having one explosive event. It was a chronic, constant method of behavior. As the culture evolved, the behavior didn’t, and so what may have been acceptable 20 years ago and below the radar was now constantly pinging about the radar as offensive comments to—racial epitaphs, cursing directly at people, criticizing their performance, criticizing their skill set in the operating room, criticizing their ability to do cases with any level of competence. Several of the residents would freeze and just come in and talk to me...

So I have 55 people [surgeons in his department] that on any given day may have a bad day. And of those, about 10 percent have more bad days than others. And then there’s—I can name three or four that have a lot of bad days. And then I can name two in my eight years as chair with—eight years as chair, I can name two surgeons that have required extensive effort and Paul by far eclipses the other. Paul occupied a majority of those efforts.

Testimony of Dr. Zwischenberger, Hearing Transcript Vol. 2 at pages 222-223 (emphasis added). Dr. Kearney’s bad behavior is pervasive, persistent, toxic and harmful. Sadly, Dr. Kearney has not changed in almost 30 years of practice at the University of Kentucky, nor does
he want to. As Dr. Kearney told this panel, he has been this way “since first grade, since my first recollection of being alive...Honest to God, that's the way I've been. That's me.” Testimony of Dr. Kearney, Hearing Transcript Vol. 2 at page 80 (emphasis added).

III. Dr. Kearney’s Justifications for His Behavior Are Irrelevant

A. The Behavior of Others Does Not Justify Dr. Kearney’s Behavior

Unable to deny critical violations, Dr. Kearney seeks instead to justify his behavior by pointing to that of other healthcare employees like nursing staff and contending they engage in similar conduct that the University is willing to tolerate. Such an “everybody else is doing it” notion is sorely misplaced for at least two reasons.

First, Dr. Kearney’s position was dispelled by the testimony of Julie Hudson, Nursing Director for the Chandler Campus’s operating room, who stated that profanity in the operating room is neither appropriate nor necessary, but more importantly, that nurses are held accountable for directing profanity at another person. Testimony of Hudson, Hearing Transcript Vol. 2 at pages 176 and 185. Hudson also testified that, in contrast to Dr. Kearney’s conduct, profanity from nursing staff “generally is not directed at another person or to berate or injure another person.” Id. at page 183 (emphasis added). As Hudson explained, “we still have to work as a team, and it doesn’t help to tear a team member down like calling them something awful.” Id. at page 184.

Second, Dr. Kearney’s finger-pointing is equivalent to the excuses of a driver who gets pulled over for speeding on the freeway. It may well be that other drivers were speeding, but it is no defense to say “everybody else is doing it” in that situation, and it is no defense to raise that argument here. Here, the inescapable fact is that the behavior happened, it violates the Behavioral Standards and it must be addressed.

B. There is No Retaliation Against Dr. Kearney
As the Hearing Panel’s chair, Dr. Mark Williams, noted at hearing, the arguments and testimony on the allegation that the decision by the MSEC was merely retaliatory are irrelevant to the questions of whether Dr. Kearney has violated the Behavioral Standards and whether he has proven grounds for overturning the Hearing Panel’s related decision about his summary suspension and privileges revocation. See Hearing Transcript, Vol. 2 at page 42. Regardless, the inescapable facts are that (1) the complaint that ultimately pushed the issue of Dr. Kearney’s behavior into these proceedings was filed by a patient and his family, not UK HealthCare administrators; (2) the MSEC’s investigators had no knowledge of an alleged threat of termination from Dr. Michael Karpf, nor did Dr. Karpf tell them how to conduct their investigation; and (3) Dr. Kearney had ample opportunity to tell the MSEC’s investigators anything he felt they needed to know, yet never mentioned his practice plan retaliation theory. See University Exhibit 7 at page UK-000037; testimony of Dr. McDowell, Hearing Transcript Vol. 1 at pages 117-118 and 159.

The simple truth established at hearing is that there is absolutely no evidence linking the “threat” allegedly made by Dr. Karpf and the MSEC decision now before this panel. All Dr. Kearney had were far-fetched inferences, conspiracy theories and the hope that such arguments would distract the Hearing Panel from the real issue at hand.

C. Arguments About the Consequence of the Incident Are Irrelevant

Dr. Kearney has also previously argued relied heavily upon the testimony of Dr. Ross Strong and upon the effects that Dr. Kearney contends the drug called Versed had on his ability to accurately recall details from his Dr. Kearney’s position is greatly flawed in at least three important ways.
First, Dr. Strong admitted at hearing that when he entered the OR, [Redacted] was already sedated and no longer struggling, and several things had already happened. *See* testimony of Strong, Hearing Transcript Vol. 1 at pages 251-253. Thus, between Strong’s testimony, the testimony of other witnesses and information about events from the MSEC’s investigation, it is well-established that Dr. Strong was not present for the entirety of [Redacted].

Second, the evidence indicates that the sedation used on [Redacted] may *not* have had the effect on memory that Dr. Kearney would like the Hearing Panel to have assumed. Dr. Berger’s testimony established that the memory impairing effects of Versed are not absolute:

> When we do the debriefing of the patients, most of them have no recollection of what happened up to an hour or so afterwards when they wake up. But, you know, there’s some personal variability between individuals....

Based on the testimony and evidence before the Hearing Panel, [Redacted] certainly is a candidate for such variability. Dr. Kearney told Dr. McDowell that [Redacted] was a [Redacted], and Dr. Peterson told Dr. McDowell he remembered a conversation during [Redacted] about what medications should be administered given [Redacted]’s history of benzodiazepine tolerance, thus indicating that [Redacted] might require a larger dose of medication or otherwise be more tolerant to sedation than other patients. *See* University Exhibit 7 at page UK-000041. Kearney further admitted to McDowell that he tries to “go light” on sedation in procedures like [Redacted]. *See id.* at page UK-000044. Caitlyn Rice told MSEC investigators that [Redacted] was awake for most of the procedure, and even Dr. Strong conceded at hearing that if [Redacted] “said [waking up during the procedure] happened, it did happen.” *See id.* at page UK-000040; testimony of Dr. Strong, Hearing Transcript at Vol. 2, page 253. Indeed, it is undisputed that [Redacted] had to be given additional sedation later into the procedure. *See id.* at pages UK-000040,
000041 and 000044. Of course, before that happened, Dr. Kearney—by his own admission—called a “dumb ass.” See id. at page UK-000044.

Third, and regardless, account of events is corroborated by the testimony of witnesses who spoke with Drs. McDowell and Bezold during the MSEC’s investigation of this case. Indeed, the testimony of witnesses cited above like Dr. Peterson and Caitlyn Rice—even the testimony of Dr. Strong and admissions of Dr. Kearney—provide ample reason to conclude that’s allegations of unprofessional, berating remarks by Dr. Kearney are true.

D. The Proceedings Leading Up To Review By This Committee Were Undertaken With All Due Caution and Care

Finally, Dr. Kearney would have this Committee believe that the MSEC’s and Hearing Panel’s decisions were reached hastily and without due regard for the facts, thus rendering it in some way unreasonable, not sustained by the evidence, or unfair. A basic review of the record presented at hearing, together with the testimony of Drs. Zachman and McDowell, demonstrates otherwise.2 The MSEC’s investigators, and in particular Dr. McDowell, were well-qualified and had full range to conduct an independent investigation. See testimony of Dr. McDowell, Hearing Transcript Vol. 1 at pages 71-72; testimony of Dr. Zachman, Hearing Transcript Vol. 1 at pages 68-69. They had adequate time to—and in fact did—interview numerous witnesses on their own accord in just a week’s time, and could have taken more time if needed. See testimony of Dr. McDowell, Hearing Transcript Vol. 1 at page 142; testimony of Dr. Zachman, Hearing Transcript Vol. 1 at page 63. They asked witnesses—Dr. Kearney included—open-ended questions that allowed for a full range of responses and information. See testimony of Dr. McDowell, Hearing Transcript Vol. 1 at pages 117-118. They made efforts to contact

2 Dr. Kearney’s complaints about administrative steps prior to and following his summary suspension such as administrative leave and emails sent to residents are likewise unfounded. As the Hearing Panel heard, the content and effect of such steps were reasonable steps taken for legitimate reasons. See testimony of Iler, Hearing Transcript Vol. 2 at pages 260 and 269-271.
Id. at page 100. They had sound reasons for not interviewing Dr. Strong. Id. at page 147. They interviewed and examined the possibility of excessive complaints from the family, only to find that the family had submitted just two complaints despite the serious behavior at issue. See testimony of McDowell, Hearing Transcript Vol. 1 at pages 106-109. They interviewed Dr. Kearney in the presence of his counsel.

Simply stated, there is no evidence that the MSEC was anything but objective, thorough and fair in its review of Dr. Kearney's summary suspension. Even Dr. Kearney's close friend and mentee, Dr. Andrew Bernard, who recused himself from the MSEC process early on, recognized that "the structure of the Medical Staff was adequate to adjudicate whatever decision had to be made." See testimony of Dr. Bernard, Hearing Transcript Vol. 1 at pages 354-355.

Moreover, the hearing conducted on May 27-28, 2015, was conducted under the direct guidance of Article 10 of the Medical Staff Bylaws. Dr. Kearney was entitled to a hearing after an adverse recommendation regarding clinical privileges by the MSEC, as allowed by Rule 10.2.1(a) of the Bylaws. The Hearing Panel and Presiding Officer (College of Law Professor Robert G. Lawson) were then appointed by the Chief Clinical Officer pursuant to Rule 10.5 and 10.6. Dr. Kearney and the University were represented by counsel at the hearing, as allowed under Rule 10.7, and both parties provided lists of witnesses and supporting documentation prior to the hearing, as required by Rule 10.8. The hearing was recorded by a qualified reporter and the Hearing Panel, Presiding Officer, and both parties received copies of the record, as required by Rule 10.9.

At the hearing and pursuant to Rule 10.10, both parties were given the opportunity to call and examine available witnesses; introduce exhibits; cross-examine any witnesses on any relevant matters; and rebut any evidence presented. As allowed under Rule 10.11, the hearing
was not constrained by traditional courtroom evidence rules and was only limited by a requirement that evidence be relevant. Additionally under this rule, the Hearing Panel took the opportunity to ask its own questions to witnesses, call its own witnesses, and request production of documentary evidence.

Both parties submitted written statements to the Hearing Panel at the close of presentation of evidence, as allowed by Rule 10.11. The burden of proof before the Hearing Panel as set out in Rule 10.13.2 then required it to recommend in favor of the MSEC decision unless it found that “the Affected Individual has proved that the [MSEC’s] recommendation . . . was unreasonable, not sustained by the evidence, or otherwise unfounded.” The Hearing Panel referred many times to this standard in its recommendation affirming the MSEC’s decision, indicating its adherence to the required standard. See Hearing Panel Recommendation at pages 1, 4, 8, 10, 11, and 12. The Hearing Panel deliberated and issued a recommendation, pursuant to Rule 10.18, in which it cited testimony from the hearing, documentary evidence, and information presented in the written statements of the parties.

Finally, as required by Rule 10.19, the Hearing Panel’s recommendation was submitted to the University Health Care Committee and the Affected Individual, as well as to the MSEC for informational purposes. It is clear that there was strict compliance with the procedure required under the Article 10 Fair Hearing Plan of the Medical Staff Bylaws. In light of this information, it is inconceivable that there a substantial failure exists on the part of either the MSEC or the Hearing Panel to comply with the Fair Hearing Plan that denied Dr. Kearney of due process or a fair hearing.

Dr. Kearney on the other hand claims that he was denied a fair hearing. He argues that he should have been allotted a hearing before the MSEC. Medical Staff Bylaws Rule 9.4.2(a) uses
the word "hearing" in describing the process to be used by the MSEC in deciding whether to take action against practicing physicians but says absolutely nothing about the nature of this "hearing." Had the drafters and adopters of the Medical Center Bylaws intended this to mean a full-blown trial type hearing they would have described in great detail the nature of the "hearing," the purpose of the "hearing," and the rights in that "hearing" of the Practitioner (just as they have done in Article 10 of the Bylaws with respect to the "Fair Hearing" to which Dr. Kearney was clearly entitled and received).

Rule 9.4.1 allows the University's Chief Medical Officer to impose a summary suspension of a Practitioner for alleged conduct violating the Bylaws and Rule 9.4.2 requires the Medical Staff Executive Committee to have an investigation done of the matters underlying that suspension (and to give the Practitioner a chance to address the matter during the course of this investigation) and then to render a decision by the whole Committee as to whether or not to move ahead with adverse action against a member of the Medical Staff. The objective of these provisions is to provide medical staff members with some limited protection against unwarranted charges of Bylaw violations (by putting into the hands of the full Medical Center Executive Committee the final determination of whether or not to proceed with formal charges against a member of the Medical Staff).

The Bylaws carefully provide for a full and fair hearing for any member of the medical staff against whom Professional Review Action is taken (as defined in Article 10). The nature of the hearing, the Affected Individual's rights, decision makers (a Presiding Officer and a Hearing Panel), and the narrow decision required of decision makers are all carefully defined in the Rules. Then the final provision of Article 10 on the Fair Hearing Plan (Rule 10.25) provides: "No Affected Individual shall be entitled as a matter of right to more than one hearing ... on any
single matter which may give rise to a right to a hearing ....” Various procedural steps were taken to provide the fair hearing to which Dr. Kearney was entitled, steps that were completed in due course as required by the provisions of Article 10. Clearly and explicitly, the Bylaws leave no room for the additional hearing argued for by Dr. Kearney.

In addition, Dr. Kearney had the opportunity to interview with the MSEC investigators and in fact took advantage of that opportunity to provide his view of the complaints against him. As Dr. McDowell explained in her testimony to the Hearing Panel, the investigators asked open-ended questions of all witnesses and allowed Dr. Kearney to add any additional information that he wished.

Q: Is it fair to say Dr. Kearney was able to tell you whatever information he felt was pertinent to his case when you interviewed him?
A: We used the same open-ended question format that we used with all of the other interviews to enable them to tell us whatever they thought was relevant.
Q: So he did have a chance to share that with you, obviously, correct?
A: Correct.

See Testimony of Dr. Susan McDowell, Hearing Transcript Vol. 1 at pages 117-118.

Dr. Kearney fully received the protection to which he was entitled under Rule 9.4, he received his “fair hearing” to which he is entitled under Article 10 of the Medical Center Bylaws, and he was precluded by Rule 10.25 from getting a second hearing on the matter underlying the Professional Review Action pending against him. For these reasons and the others stated herein, there are no grounds for appeal that there was any substantial failure on the part of the Hearing Panel or the MSEC to comply with the Fair Hearing Plan so as to deny due process or a fair hearing.

CONCLUSION
This Committee is charged with determining whether Dr. Kearney has proven that the Hearing Panel’s recommendation affirming the MSEC’s decision about his summary suspension and privileges revocation was not supported by the evidence; was made arbitrarily, capriciously, or with prejudice; or that there existed a substantial failure on the part of the MSEC or Hearing Panel to comply with the Fair Hearing Plan, so as to deny due process or a fair hearing. For the reasons above, Dr. Kearney has fallen far short of meeting this requirement. Accordingly, the Bylaws require this Committee to uphold the Hearing Panel’s decision.

This Committee cannot decline to confront Dr. Kearney’s recalcitrant and utterly unprofessional behavior, nor the risks to patient care that it creates. As Dr. Griffith noted in reviewing Dr. Kearney’s 2014 classroom lecture, “The standard you walk past is the standard you accept.” See University Exhibit 7 at page UK-000080. The University cannot accept the standard set by Dr. Kearney. Thirteen physicians at the University unanimously found that Dr. Kearney’s behavior violated the Behavioral Standards. The three physicians comprising the Hearing Panel found the MSEC’s decision was reasonable, sustained by the evidence and sufficiently well-founded. And, like the Hearing Panel found, “nothing short of the severe sanction” of revocation of clinical privileges is going to cure this problem. This Committee should uphold the Hearing Panel’s decision and find that the recommendation was supported by evidence; was not made arbitrarily, capriciously, or with prejudice; and that there exists no substantial failure on the part of the MSEC or the Hearing Panel to comply with the Fair Hearing Plan.

STURGILL, TURNER, BARKER & MOLENEY, PLLC

BY: 

[Signature]

Bryan H. Beauman
Joshua M. Salsbury
CERTIFICATE OF SERVICE

The undersigned does hereby certify that on July 24th 2015, a true copy of the foregoing was served by email and U.S. Mail, First Class postage prepaid, to:

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