HEARING PURSUANT TO ARTICLE 10 OF UK HEALTHCARE MEDICAL STAFF BYLAWS FOR PAUL KEARNEY, M.D.,

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HEARING BEFORE: Professor Robert G. Lawson

DATE: May 27, 2015 (VOLUME 1 OF 2)

TIME: 9:00 A.M.

PLACE: University of Kentucky
Charles G. Wethington Jr.
Building, Room 127
900 South Limestone
Lexington, Kentucky 40536

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EXHIBITS MARKED

PROFESSOR LAWSON: Okay. At the outset, I want to just provide some basic information for the record. My name is Robert Lawson. I'm a retired professor of law here at UK and an attorney. I'm acting under the Medical Center's bylaws as the presiding officer over this hearing. Under the bylaws, the three individuals with me at this hearing are serving as the hearing panel, these three here. Dr. Mark Williams is acting as the panel chair. The other two members are Dr. Wendy Hansen and Dr. Lisa Tannock. The Medical Center bylaws bestow upon the hearing panel the authority to determine if an action taken against a member of the medical staff -- I'm quoting from the bylaws -- "is unreasonable, not sustained by the evidence, or otherwise unfounded." The focus of the hearing is a professional review action taken against Dr. Paul Kearney by the

Medical Staff Executive Committee and made known to Dr. Kearney on February 10, 2015, by letter from Dr. Frederick Zachman, the acting president of the medical staff. The university, and specifically UK Medical Center and Medical Staff Executive Committee, is represented in the hearing by outside counsel, Mr. Bryan Beauman and Mr. Josh Salsburey. Dr. Zachman will be with you-all soon sitting as acting president of the medical staff. Dr. Paul Kearney is present in person at the hearing and is represented by his own attorney, Mr. Bernard Pafunda. The university is required by the Medical Center bylaws to maintain a record of the proceeding before the hearing panel. We have selected a court reporter to make this record, and that person will be present for the full hearing and will provide participants a transcript of the hearing after it

is over. The hearing will begin with opening statements from each side, first by counsel for the Medical Center, then by counsel for Dr. Kearney. There's a 15-minute time limit on these statements. We will begin now with the Medical Center's opening statement.

MR. BEAUMAN: Thank you, Professor Lawson. Again, I am Bryan Beauman with the Lexington law firm of Sturgill, Turner, Barker & Moloney. We're outside counsel on this matter to the university, not in-house. I appreciate your-all's time here today, and I first want to thank the three of you. No one wants to be here today to endure this process. It is not one that the university goes through very frequently, but I understand that and certainly appreciate your willingness to serve, recognizing what your role is and what your responsibility is. As medical staff and physicians here,

you have students in training, as do we. The other person that wasn't introduced to you earlier is Meredith Byrd, who is a law student here at the University of Kentucky and working with us this summer and will be assisting us on this matter as well. So we'll take about the next 15 minutes and kind of explain to you why we're here, how we got here, what you can expect over the next day and a half to two days, and even then as your work goes forward. But before I talk about what this case is about, I want to talk a little bit about what the case is not about. The case is not about Dr. Kearney's skills as a physician and as a surgeon. That is not in question here today. No one doubts that he has the highest credentials, great training, great performance, and year after year his knowledge certainly in dealing with trauma patients is not what's in question,

and that's not why we're here. We are not here about those skills as a physician, but as you-all know, as your colleagues on the Medical Staff Executive Committee know, as Dr. Boulanger knows and will testify to, there's much more to being a physician, and especially a physician in a teaching hospital like the University of Kentucky, than just your skills as a surgeon. It deals with your professionalism, your courtesy, your interaction with staff, and your interaction with students, and that's what we're here about today. I want to take you through a couple of timelines, but first, let me talk about what your role is as the hearing panel. The medical staff has bylaws -- it applies to you, Dr. Kearney and all staff, and you're familiar with them -- that entitles him to this hearing before you as a third step in the process. And I'll walk you

through both those steps, but I want you to keep in mind what your role is. Your role serves as reviewing the recommendation and investigation of the Medical Staff Executive Committee. And what the bylaws provide is that you shall recommend in favor of the committee unless one of three findings you can reach: That Dr. Kearney and his attorney prove that the Medical Staff Executive Committee's recommendation was either unreasonable, not sustained by the evidence, or otherwise unfounded. So all the evidence and all the testimony that you receive in review over the next two days and then the follow-up period, that's your standard that you look at. Was the MSEC recommendation unreasonable? Was it not sustained by the evidence or otherwise unfounded? Let me talk about the facts and tell you how we got here. We're going to start with

[redacted], and I can tell you [redacted] -- we're going to be using that name -- that's a patient here, but for this process it's permissible for us to talk about his condition and his treatment. He was a spinal cord injury patient that Dr. Kearney, as well as many others, had treated during his inpatient time here. He was scheduled for a [redacted] on [redacted], before he was being transferred to another facility. There's no question that that procedure had some difficulties at multiple levels. As the [redacted], the resident who was performing that part of the procedure, Justin Peterson, [redacted]. There was some resistance from [redacted]. Although quadriplegic, he did have some movement in his shoulders and upper extremities and there was some

resistance there. There was [redacted], and there were some [redacted]. So there was difficulty that Dr. Peterson had in that procedure at the beginning. [redacted], and then finally when the [redacted] there was also difficulty there that Dr. Peterson encountered in trying [redacted] at that time. The testimony that you are going to hear is that during the procedure Dr. Kearney made comments such as, and I apologize for the language, but I need to repeat verbatim what has been reported, that when [redacted] was struggling with his mouth, that Dr. Kearney makes the comment, "Just pry his fucking mouth open," and that he either calls [redacted] while he was awake either a "fucking idiot."

Dr. Kearney will admit that he says to [redacted], "Hey, dumb ass, we're just trying to help you. Relax." At a separate point, not during this procedure, there's question about [redacted]'s [redacted] and some discussion about his spinal cord impairment. In the hallway, Dr. Kearney refers to [redacted] as a "fucking quad," and that is overheard by [redacted]. So how this advanced is a complaint, an internal complaint, is filed by the family. Dr. Boulanger will testify that he received the complaint by e-mail on September 4. As he read it, he can tell you what stuck out to him about receiving that e-mail. He will tell you he knew he needed to take immediate action. He spoke with Dr. Kearney. He also the next day interviewed [redacted] himself, conducted the interview. Dr. Boulanger will tell you what [redacted] reported and what the

assessment of [redacted]'s report was and that he realized that there was credible evidence and he knew that further action needed to be taken. So he takes a few immediate steps. First, Dr. Kearney is placed on administrative leave. As Dr. Boulanger will tell you, that's for multiple purposes, including Dr. Kearney's own benefit at the time to allow the factual investigation to take place. Dr. Boulanger has Cliff Iler conduct the factual investigation, interview multiple witnesses who were present at the scene during the procedure. They all report back to Dr. Boulanger. Meanwhile and unrelated to [redacted], [redacted], who was another employee at the university as a tech, leaves the university. Inquiry is made to her about some outstanding debt she owed the university when she left, and she responded, "I cannot believe how

I was treated while there." So the question was asked to her and she responds, and we'll see the e-mail that she wrote back, that the treatment she had from Dr. Kearney, his conduct that she just could not be around. There was an incident where a bipolar machine, as she describes it, was not working properly during the procedure. She claims that Dr. Kearney blames her for it, calls her a "fucking idiot" and a "fucking moron," and what the facts actually reveal is that the resident had his foot on the wrong pedal and that's why the machine was not responding properly. So after assessing all that information, what Dr. Boulanger will tell you is that he realizes he needed to remove Dr. Kearney from the care environment. At that point he turns it over to the general counsel's office. Lawyers do what lawyers do. Hopeful that some resolution can be

reached with Dr. Kearney. A few months pass. That did not occur. So it comes back to Dr. Boulanger, who issues the summary suspension of Dr. Kearney's privileges on January 26th. This is where the timeline picks up and you guys soon get involved. So under the medical staff bylaws, that suspension is then turned over to the Medical Staff Executive Committee. They meet on January 29 and report -- report -- excuse me, two of their members, Dr. Susan McDowell and Dr. Louis Bezold, to investigate the matter and report back. Dr. McDowell will testify today. She'll explain to you what they did and what they looked into and what their findings reported back to the Medical Staff Executive Committee were. They do that investigation over the course of a few days. The Medical Staff Executive Committee meets back on February 15 of 2015,

unanimously voting to uphold the suspension of Dr. Kearney's privileges. So under our bylaws, notice is given to Dr. Kearney through his attorney on February 10th, and they write back asking for the hearing, which is today, which he certainly is entitled to do under the bylaws. That then triggers the university's obligation to do the notice of hearing. All these are exhibits which you'll see before you as we go through them over the next couple of days. So the university prepares the notice of hearing, which includes all the charges against Dr. Kearney, saying that they were drafted and were to be part of the process. But what the Medical Staff Executive Committee looked at and what Dr. Boulanger certainly knew was that these were not two isolated incidents but instead, unfortunately, was part of a pattern of behavior that

Dr. Kearney had exhibited dating back to 1992. Dr. Boulanger will explain to you he thought that after 2012 that this situation had been resolved, and I'll show you why in just a second. But if we go back to 1992, some of you may remember or may know of Dr. Byron Young, who in the 1990s was chair of surgery, and apparently there was an incident in March of '92 when Dr. Kearney is on rounds and needs equipment and so demands that the chair's staff provide equipment to him, as Dr. Young writes up Dr. Kearney, and describes his behavior as rude, offensive, impolite, arrogant, and loud. Again, these documents will be before you later. Next, in 1995, Dr. Milligan, who was formerly an OB/GYN, practiced here at the university, writes to Dr. Young, again complaining about Dr. Kearney's behavior. There was an incident that evening with a lady

involved in a motor vehicle accident who suffered a [redacted] and loss of a 20-week fetus. Dr. Kearney had concerns, and I suppose there was a debate between he and Dr. Milligan, about the response of the attending OB. Dr. Milligan consulted with Dr. Kearney multiple times during that night, but unfortunately Dr. Kearney announced during rounds that the attending OB was too lazy to get up in the middle of the night, which is what caused the unfortunate outcome. Dr. Milligan expresses his concern because, A, not only were the facts not accurate, but these comments were unprofessional, detract from patient care, leads to finger pointing, undermines interdepartmental cooperation, and importantly presents a poor standard of behavior in front of residents when they're in training. In 2000, there's

multiple reports by OR nurses [redacted], and [redacted], about what I would almost describe as locker room-esque behavior. I apologize for this. Dr. Kearney grabs his crotch and says, "Hey, I've got something here for you, Frank," referring to Frank McDowell -- Frank McDonald, excuse me -- and then continues to make disparaging remarks about ethnic minorities, gays and lesbians, Christians, and women. The three nurses were appalled by his behavior. They report it. Dr. Young offers Dr. Kearney a voluntary remediation based on this conduct, which included evaluation by mental health professionals, written apologies, and a five-day leave. And most specifically, Dr. Young notes that the failure to meet these requirements or acting in a similar manner in the future will result in future corrective action

and may include termination. That was in 2000. Moving forward to 2005, Dean Jay Perman, with the College of Medicine, writes Dr. Kearney about a profanity-laced outburst in the course of caring for trauma patients. You'll see in this memo he also refers to an instance six months prior in December of 2004 and conversations that he had had with Dr. Kearney, and then Dean Perman notes, "There is zero tolerance for this type of behavior, and it demeans our entire institution and all of those who practice here." The next incident occurs in 2009. This is a memo you'll see in the exhibits from Dr. Zwischenberger, who of course you know is the Chair of the Department of Surgery; Dr. McGrath, Dr. Kearney's immediate supervisor, the chief of general surgery; Dr. Depriest, who was then the Chief Medical Officer; and Colleen Swartz,

who is the Chief Nurse Executive. This deals with the continuing course of behavior which they found demeaning, insulting, and unprofessional. They note that he continues to exhibit aggressive and humiliating behavior around colleagues and staff. There have been numerous complaints, and his attitude is seen as derogatory and impacting on student education. Now come forward to 2012. Dr. Boulanger is now in a position where he's overseeing this discipline, three separate incidents over the course of 2012. I'm sorry to go so fast, but I'm trying to be respectful of all of our time here. In May of 2012, a nurse, [redacted] is scrubbing into the operating room to relieve a nurse in that procedure, and as she steps to the table, Dr. Kearney greets her with, pardon me, "Hey, bitch," as she steps to the table. In August 2012, [redacted]

[redacted] is in charge of finding a replacement nurse for a nurse who became sick during a procedure on a [redacted] that Dr. Kearney was performing. It takes her somewhere between eight to 15 minutes to find a replacement. After the procedure, Dr. Kearney goes to her desk and in front of two other employees and an employee's father he says to [redacted] "You should wear a colostomy bag over your head because you have shit for brains." This is not in dispute. In September 2012, a month after that, [redacted] is in an operating procedure with Dr. Kearney. She immediately calls out -- makes a mistake, calls out the wrong procedure, but immediately corrects herself, and he reaches over with an open hand, slaps her on the shoulder hard enough to leave a red mark. She complains about that by saying something to the extent of

saying, "Hey, I'm pregnant," to which Dr. Kearney responds, "Well, whose fault is that?" So these three issues come to Dr. Boulanger's attention in 2012. He will tell you what he reviewed and the actions he took. And what happens is Dr. Kearney is given a reprimand and an agreement, which you'll see. This is all going to be in the materials and, in fact, is the first few pages of your exhibits. You'll see that the purpose is to correct this behavior and to prevent any recurrence. Dr. Kearney agrees to refrain from unprofessional conduct in interacting with UK personnel, specifically not to slap anyone when angry or frustrated, and not to direct profane comments toward UK personnel if they fail to perform duties adequate to him. It is signed by Dr. Kearney, January 9th, 2013, specifically noted that the document will be placed in his

personnel file, and as number five points out, if he violates the terms of this action plan, he'll be subject to corrective action.

PROFESSOR LAWSON: You need to finish up in about a minute.

MR. BEAUMAN: I will wrap it up. 15 months later is the [redacted] incident, and we learned the [redacted]. As you-all are aware, there are behavioral standards for patient care and commitments to performance. You've all signed it. This is Dr. Kearney's, and he signs this two months after his written reprimand. Dr. McDowell will testify about those today and why the Medical Staff Executive Committee reached the decision they did. I thank you all again for your time over the next couple days.

PROFESSOR LAWSON: Mr. Pafunda.

MR. PAFUNDA: Thank you, Professor [redacted]. Panel members, let me start out, if you'll write down just one

word, "Versed," and it's going to come into play with respect to Patient [redacted]. Dr. Kearney did not call Patient [redacted] a "fucking quad." It didn't happen. In fact, the investigative committee who did the investigation for the Medical Staff Executive Committee failed to interview some key witnesses. One of those witnesses was a resident who was in the -- you'll have to excuse me, but I have caught the crud -- was in the endoscopy suite and was present and will tell you he did not hear Dr. Kearney call Patient [redacted] a "fucking quad." More importantly, [redacted] has told everybody that he was called a "fucking quad" by Dr. Kearney while he was in his room several days before the [redacted] and that a female resident was with Dr. Kearney when he uttered that statement. The female resident, who was never interviewed in this

investigative process, will tell you that Dr. Kearney never said it. Well, if that be the case, then the question arises, "What's going on?" And if I may, and not have it counted against my time, you said you would help me.

MR. BEAUMAN: Yes. I'm sorry.

MR. PAFUNDA: We're sharing a laptop, PowerPoint. My motto is everybody's PowerPointed to death. Thank you. I appreciate it. This is a rather unusual procedure for lawyers. We are not in front of a jury. We're not in front of a judge. We're in front of doctors, and that can lead to quite a few questions. Nurse [redacted], you may want to write it down because in Dr. Kearney's personnel file that complaint was falsified, and we'll prove it to you. In fact, you saw the second page of that that Dr. Kearney signed. The document that was placed in his personnel file was

never signed by Dr. Kearney. In fact, there was an amendment to the one that he did sign. Now, the question arises, I know, why would somebody put a false document in Dr. Kearney's file? Is it as the university says, after 20 years of bad behavior that we're now here? You have to ask yourself the question, "Why now?" Is it Patient [redacted], and is it [redacted]? Dr. Kearney doesn't remember [redacted]. [redacted]'s letter to the university is, "I don't want to pay you and here's why, and I'm going to hold over your head another doctor, Dr. Kearney." This [redacted] matter was never in his personnel file. And if we go back to 1992, Dr. Milligan, what they didn't show you is Dr. Kearney's response. The complaint was by Dr. Kearney over patient care. The patient wasn't receiving care. Dr. Milligan is no longer here. Dr. Kearney has been

here for 27 years. They say, "Well, we agree he's a skilled surgeon." Not the case because what we're talking about is professional conduct, so we have to look at 27 years of professional conduct. And what has the man achieved? Is he unprofessional, or is he professional? Is the punishment that's been doled out unreasonable? The Medical Staff Executive Committee, did they have all the information? You will hear from the investigator, Susan McDowell, that after her investigation she'll tell you she put Dr. Kearney down as a job reference. She's looking to bail, and she will admit to you she didn't have all the information. So let's just walk through his pattern of professional conduct. As you can see, board certified and recertified from 1988 to 2009, and here's the most interesting part. If he was so unprofessional over all these years,

he's promoted from assistant professor of surgery, regular title series, to associate professor and full professor, regular title series, tenured professor. This is in 2000. If we've got a rogue surgeon out there, surely he wouldn't have been promoted. And that's what worries the lawyers.

MR. BEAUMAN: Which button did you push?

MR. PAFUNDA: I pushed the bottom.

MR. BEAUMAN: Oh, no, you stopped it. Here you go. This button.

MR. PAFUNDA: Thank you. Annual faculty performance evaluations, you will have those in front of you done by his division chief, his supervisor, signed off by the dean, all excellent with the exception of one, and one has a note on it. Each of these yearly performance evaluations mentions the following, specifically: They applaud him for his professionalism, clinical excellence, education, leadership,

and academic excellence. What he's achieved in the academic realm and in the surgery realm is reflected in the awards that he has received over the years: AOA; he enjoys an endowed chair in surgery in his name; honorary doctorate; Best Doctors in America 12 times; America's Top Surgeons seven; times, Hippocratic Award for Excellence in Medicine, 2013. Again, 26 years of student and surgical resident teaching evaluations. He has won eight times the Ward O. Griffen Award, the Gordon Hyde Award, School of Nursing, Off-Service, Richard Schwartz Leadership in Education, 2012, which announces his professionalism and leadership. At the same time that there are those who are saying he was unprofessional, he receives these awards. Four invitations to hood medical students at graduation. I'll stop right here with Richard

Schwartz. I don't know how many people on the panel are familiar with Richard Schwartz, but one of the arguments that the penalty is unreasonable, suspension of clinical privileges, also has to do with has there been an arbitrary treatment, a capricious treatment of doctors who have engaged in more egregious acts than Dr. Kearney, in fact have jeopardized patient care. And we'll explore that through the witnesses who we'll present at this hearing. 80 peer-reviewed scientific publications, 40 published abstracts, 84 scientific meeting presentations, visiting professorships, international invited presentations, 24 national invited presentations, 65 regional invited presentations. Well, a clinical surgeon's on duty/on call. American Board of Surgery nominee, invited examiner for certifying exams, 52 industry-sponsored

clinical trials as both a personal investigator, co-investigator, and sub-investigator, fellowship associations within his field and chosen profession as a surgeon. Again, what stands out as stark contrast to the charge here is we have a trauma program director from 1992 to 2011, underscoring and highlighting his professionalism. Chief, Section of Trauma and Critical Care, 1992 to 2011. Medical Director Trauma and Surgical ICUs, 1988-2010. Program Director, Surgical Critical Care Fellowship, 1993 to 2013. These are the administrative services that he's provided to the university in addition to accomplishing those particular feats while an active surgeon. Here he is again in an administrative capacity. Anatomy Course Director -- Co-Director, excuse me, 2012 to the present time. Unprofessional? He's stepping in,

and he's stepping up, and he's recognized for his professional behavior. And here's the service that he's provided to the state. To me as a lawyer this is the most important one, and I don't know why. It's my personal opinion, but his surgery on Sunday, he volunteers for work. So it underscores the fact that he's willing to even service, of his own free time, the poorest among us who can't otherwise afford those outpatient types of surgery, and now he stands as the chairman of that particular charitable organization.

(SOTTO VOCE DISCUSSION.)

MR. PAFUNDA: Thank you. So the questions become, is his suspension of his clinical privileges unreasonable? Is it unfounded or not substantiated by the evidence? And our first approach is that it's unreasonable. The second approach it's unfounded, and that's why I say

"Versed"; that word is going to play an important role as concerns Patient [redacted]. You're going to hear people say that Dr. Kearney called him a "fucking quad." The question is going to become whether [redacted], when he was on the table being [redacted], was he conscious? And if he was unconscious, when he woke up later, was he able to remember what occurred? You're going to hear opinions that, no, in all probability even to the extent of 99 percent from an anesthesiologist that he wouldn't remember a word. So where did it come from? You'll hear -- we're going to call the patient care manager who investigated this complaint along with Dr. Boulanger, who addressed this complaint personally at the time and who also brought with him two lawyers, Cliff Iler and Margaret Pisacano. And [redacted] will tell you that during

those meetings with the [redacted] family, the story seemed to grow. So it's going to come down to: Did the [redacted] make it up, or did they lawyer up when he arrived here? And he's going to admit that he was lawyered up. And I've never met the man, never spoken to him. And you will hear from nurses who attended to [redacted] in the ICU that the mother constantly complained about the care he was receiving. And the good care, and I'm reluctant to use the word, but the professional care that he received when he was [redacted] came from Dr. Kearney. It cleared the patient up. His [redacted] [redacted] were gone. He stopped the resident who was [redacted], and he had to stop that student and asked another resident to step in, and the procedure was completed. And the next day Dr. Kearney went to Patient [redacted]'s room and said, "I know it

was [redacted]," so on and so forth, "How are you doing?" And [redacted] tells him to get out of the room. They had criticized every physician who attended [redacted] from the time he arrived here, and [redacted] will tell you that. So why does the university have to reach back 20 years? Why now, in the face of that professional credentialing and his accomplishment? I'm going to take one more step. And, again, I apologize, but a resident gave this to me. On April 14th last year, Dr. Kearney, as a member of the Faculty Council met with Dean de Beer, Dr. Karpf, the general counsel, Bill Thro, and he reported to these individuals that Dr. Karpf was breaking administrative regulations. And Dr. Karpf's response immediately was he threatened to fire this man. All of a sudden a few months later the

[redacted]' complaint surfaces. Several months later the [redacted] complaint surfaces. It was never in his personnel file. In fact, according to regulations, matters of -- university regulations, matters were put in his personnel file, and he was not given the opportunity to respond. For the first time, when I secured the personnel file in the beginning of October, he got to see his personnel file, and the document you saw that he signed in 2013 wasn't in it. It was supplied later after January. There are some who would say the die is cast. That would be the university. I say that's not the case. There's more afoot here. All we ask is that the panel listen. If you have a question or if I stumble, don't hesitate to ask. I think they have the right to ask questions.

PROFESSOR LAWSON: Yes.

MR. PAFUNDA: Thank you. Thanks for

your attention.

PROFESSOR LAWSON: Okay. That concludes the opening statements, and the university will be the first to produce their evidence, so call your first witness.

MR. SALSBUREY: The university calls Dr. Frederick Zachman.

MR. BEAUMAN: Is everybody good for lights? I think we're done with this screen.

MR. PAFUNDA: Yeah, thank you.

PROFESSOR LAWSON: Okay. We'll proceed again with the introduction of evidence. Dr. Zachman, all of the witnesses who are testifying for the hearing panel will be asked to affirm that they will testify accurately and truthfully. On behalf of the hearing panel, I will ask if you will commit to do that in giving your testimony.

THE WITNESS: I will.

PROFESSOR LAWSON: Proceed.

MR. SALSBUREY: Thank you.

(REPORTER SWEARS THE WITNESS.)

FRED ZACHMAN, M.D.,

testified as follows:

EXAMINATION

BY MR. SALSBUREY:

Q Good morning, Dr. Zachman.

A Good morning.

Q I would like to, before we get started, present to you -- your panelists have this as well; everyone does -- this is a binder of evidence that the parties have agreed is submitted on behalf of the university. You don't need to refer to something there unless I ask you to refer to something in there.

PROFESSOR LAWSON: Let the record show that this has been added to the record. It is the university's book of exhibits.

MR. SALSBUREY: Thank you, Professor.

BY MR. SALSBUREY:

Q Dr. Zachman, just for the record, can you state your name and your current position with the university?

A My name is Fred Zachman, and I'm a member of the faculty, the Department of Obstetrics and

Gynecology. In this matter I'm acting as the President of the Medical Staff.

Q Okay. And how long have you been with the university?

A Since July of 1999.

Q How long have you held your current position -- excuse me. You said you were Chief of general obstetrics?

A I was named Division Director of General Obstetrics and Gynecology in September of 1999.

MR. PAFUNDA: We would ask the doctor to speak up just a little notch more. It's a big room.

THE WITNESS: Okay.

MR. PAFUNDA: Thank you. I appreciate it.

MR. SALSBUREY: Thank you.

BY MR. SALSBUREY:

Q You said currently you're also serving as acting President of the Medical Staff Executive Committee?

A In this matter I am, yeah.

Q This matter referring to Dr. Kearney, correct?

A That's correct.
Q Has your Executive Committee ever had cause to review a summary suspension of Dr. Kearney by Dr. Bernard Boulanger?
A I was asked to review that summary suspension in January this year.
Q Okay. I'd like you, if you can, to walk us through your committee's work with that summary suspension, what your committee was responsible for.
A Okay.
Q You said you were asked to review that. How did that begin?
A So in January --
PROFESSOR LAWSON: Excuse me just a second. Mr. Beauman, you're talking about the Medical Staff Executive Committee?
MR. SALSBUREY: Yes, sir. My apologies.
PROFESSOR LAWSON: Let the record show that.
MR. SALSBUREY: If I might, I'm Mr. Salsburey. This is Mr. Beauman.
PROFESSOR LAWSON: I'm sorry.
MR. SALSBUREY: That's all right. I've

been called worse things.
BY MR. SALSBUREY:
Q If you can, go ahead and start us with January of this year when you said this matter came to your committee's attention.
A So on January 20th of this last year, Dr. Boulanger notified me that he had an important medical staff matter that he needed to discuss with me and that Dr. Andy Bernard had recused himself of his responsibilities and I was responsible for taking the next step. He asked that we meet in the office with him on January 21st. On January 21st, Bernie and I sat down in his office, and Kevin Nelson was also there and Cliff Iler was also there.
Q Okay.
A At that point Dr. Boulanger reviewed with me the facts of the case, of his decision to perform a summary suspension for Dr. Kearney.
Q Okay. And those were the only persons present at that first meeting?
A That's correct.
Q Okay. And what -- after that meeting, was there any kind of written documentation sent

out following that meeting?
A So not -- at that meeting Dr. Boulanger informed me that the likelihood was high that he was going to need to perform the summary suspension.
Q Okay.
A Then on the 26th he informed me that he was going to recommend that kind of action be taken.
Q I'm going to turn your attention to Tab 5 in the binder, as well as our panelists. You will see, Dr. Zachman, that the page numbers in this have also been paginated in the bottom right-hand corner, to try to make that a little easier for everyone this morning. You had talked about a January 26 documentation.
A Yes.
Q Do you recognize that Tab 5, page 29, do you recognize this document? It's a two-page document.
A Yes, I recognize this.
Q Can you tell the panel what this document is?
A This is the notification of Dr. Kearney of Dr. Boulanger's decision to perform the

summary suspension that day.
Q Okay. And on the second page, what's paginated as page 30 at the bottom, there's a line of cc's or copies to. Do you see that?
A Yes, I do.
Q And what is the last copy recipient?
A UK HealthCare Medical Staff Executive Committee.
Q And that is, in fact, your committee that we're talking about right now?
A That is correct, and this was delivered to me in that capacity.
Q Okay. After that, after that notice was sent out and received after your meeting with Dr. Boulanger, what came next in the process for the Executive Committee?
A So after I received this letter, I provided notification to the Medical Staff Executive Committee of our need to discuss this matter. I reviewed with them a time that we could meet, and I think on January 29th we met as the Medical Staff Executive Committee to discuss the needs and requirements that were set forth in the bylaws.
Q Okay. And did you, in fact, have a meeting?

A We did.
Q Would you turn your attention to Tab 6. It would be starting at page 32 in your binder. Before I do that, did you keep minutes of this meeting, or did someone keep minutes of the meeting you just described?
A These are the minutes from that meeting.
Q Okay. And if I'm correct, there are two pages here, pages 32 and 33?
A That is correct.
Q Would you take a moment just to look at those, please, Dr. Zachman? Are those, in fact, a fair and accurate copy of the minutes that were kept in that January 29 meeting?
A This is a fair and accurate representation.
Q Does your committee usually keep minutes in the course of its meetings?
A We have minutes of each meeting, yeah.
Q Okay. Okay. Excuse me. At that meeting, did your committee determine a scope of the inquiry that you were about to make?
MR. PAFUNDA: Professor Lawson, if it will help matters, he can ask him leading questions.
MR. SALSBUREY: Okay. I'm trying not to

step on your toes.
MR. PAFUNDA: I've got no objection.
MR. SALSBUREY: We'll try and make this a little bit easier.
BY MR. SALSBUREY:
Q Did you, in fact, determine the scope of the inquiry your committee had to conduct?
A Yes, we did.
Q And reflected there on page 32, is that the determination of what your inquiry was, your scope was? If you'll look at maybe the second paragraph there, main block.
A Yes. We had made kind of a review of the bylaws and our decision with exactly what we needed to do as the Medical Staff Executive Committee.
Q And for the panel's benefit there, can you read that second paragraph in that block?
A "This called meeting is the second of several steps in the Medical Staff Bylaws process. As the Medical Staff Exec Committee, this group has 14 days to suspend, amend, or rescind the suspension. Grounds to sustain the suspension consist of whether there are reasonable grounds to believe that the

allegations are true. They don't have to be proven conclusively true at this stage. The purpose of this step is to ensure that the summary suspension is not capricious, motivated by personal or professional vendetta."
Q Okay. And, in fact, you were looking, as I see in your minutes, at a number of incidents, correct?
A That's correct.
Q And one of those incidents was inclusive of a patient named [redacted], correct?
A It was.
Q Okay. Did you take any other action other than determining the scope? In other words, did you appoint anyone to handle an investigation in this matter?
A So one of the things that we did within this meeting was develop an investigative group to look independently at the facts of this case.
Q Okay. And who did the committee select?
A We selected Susan McDowell and Louis Bezold.
Q And who is Susan McDowell?
A She is one of the faculty here who is responsible for the GME Office, or the

Graduate Medical Education Office, and also is responsible for the Department of Physical Medicine Rehabilitation.
Q And Dr. Bezold, who is he?
A He is a pediatric cardiologist and one of the elected at-large members of the Medical Staff Executive Committee.
Q Okay. And was there a consensus as to those two being selected?
A There was.
Q Okay. Looking at your minutes, is it correct that the medical staff's behavioral standards were made available for the committee's review at this meeting?
A Both the bylaws and the behavioral standards were provided to the members of the Executive Committee.
Q Okay. So you appointed your investigators, and was there any other significant action at that particular meeting after appointing your investigators?
A There were no other significant matters aside from providing simple review of kind of the basics of the case.
Q And you, yourself, did not conduct an

investigation?
A I did not.
Q Okay. So what was the next step, then, after that meeting for you as acting president?
A I provided Susan and Louis with enough time to perform their investigation, and then we called a second meeting to review the hearing of the facts of the case.
Q And when was that meeting?
A That was on February 5th.
Q Okay. Would you turn to Tab 8 in your binder, please, Dr. Zachman, I believe starting at page 89 continuing through page 90. Do you recognize the document there at Tab 8?
A I do.
Q What is that?
A This is the minutes from our second Medical Staff Executive Committee meeting.
Q If you'd take a moment just to look at that, please. With the exception of redaction of patient's name -- we are referring to him today as [redacted] -- except for that redaction, does that appear to be an accurate copy of those minutes?

A This is an accurate copy of our final minutes.
Q Was an investigation and, in fact, was the results of Dr. McDowell's and Dr. Bezold's investigation presented to the committee on February 5th?
A Yes. They were presented by Susan and Lou in open session before we went to closed session.
Q Okay. Do your minutes there contain an accurate summary of what they reviewed with your committee?
A It provides what was included in Dr. McDowell's and Dr. Bezold's report.
Q And they did, in fact, submit a written report?
A They did.
Q Okay. What action was taken ultimately at the course of this meeting?
A The Medical Staff Executive Committee made the unanimous decision to uphold the suspension.
Q And was that inclusive of Dr. Boulanger's recommendation to revoke clinical privileges?
A It was.

Q Okay. Did you ever notify Dr. Kearney of this decision?
A Yes, he was notified.
Q Okay. Would you turn to Tab 9 in your binder there, Dr. Zachman? Doctor, at pages 92 and 93, take a moment and look at that and let me know when you have, please. Dr. Zachman, do you recognize that document at Tab 9?
A Yes, I do.
Q What is it?
A It's a letter informing Dr. Kearney of our actions as the Medical Staff Executive Committee.
Q That is, in fact, a letter from you, correct?
A That is correct.
Q As acting president of the Executive Committee?
A That is correct.
Q What is the date of that letter?
A That was on February 10th.
Q Okay. And excuse me, but that letter did, in fact, inform Dr. Kearney of his right to the hearing we're at today, correct?
A That's correct.
Q And it informed him of the possibility of

revocation of staff privileges, correct?
A Correct.
Q Okay. After sending that letter to Dr. Kearney, did you as acting president have any further role with respect to the investigation or review of Dr. Kearney's summary suspension?
A I had none.
MR. SALSBUREY: Professor, that's all I have for the witness.
PROFESSOR LAWSON: Mr. Pafunda.

EXAMINATION

BY MR. PAFUNDA:
Q Dr. Zachman, my name is Bernard Pafunda.
PROFESSOR LAWSON: Speak louder, please.
MR. PAFUNDA: Okay. I will. I don't know if I can.

BY MR. PAFUNDA:
Q My name is Bernard Pafunda, and I represent Dr. Kearney. Good morning.
A Good morning.
Q You've known Dr. Kearney how long?
A Since 1999.
Q All right. And that's when you came on board here at the university?

A That's correct.
Q In what capacity, Doctor?
A Did I come on board?
Q Yes.
A I was a faculty member of the Department of Obstetrics and Gynecology.
Q And your job duties included what?
A I was a clinical faculty member and also responsible for our Division of General Obstetrics and Gynecology.
Q And your present day chairperson is?
A Dr. Hansen.
Q All right. Where did you train?
A I trained in medical school at Indiana University and in residency at the University of Cincinnati.
Q And your prospects for the future -- for your future here at the University of Kentucky is what? What do you want to achieve?
A What do I want to achieve?
Q Yes, please.
A Well, my goal is to develop, you know, generalists in general obstetrics and gynecology clinical program here and potentially carry that forward into different

parts of the state to develop women's health infrastructure for kind of Central and Eastern Kentucky.
Q And have you taken steps in that direction?
A I have.
Q Has Dr. Kearney helped you in any way with respect to any of your plans or your tenure here at the University of Kentucky?
A I don't know of anything specifically that Paul and I have developed together in terms of a clinical program. We've worked together as faculty members.
Q And if I may, just in the street language, you work in different spheres; is that correct?
A That's correct.
Q And so are you familiar with the trauma surgery itself in terms of being hands on?
A Yeah.
Q All right. And what is your understanding with respect to that?
A I think trauma surgery is, you know, it's a 24/7 clinical program that takes care of very critical patients.
Q Would you agree with me that it's a stressful

environment?
A It can be very stressful.
Q And I take it at some point in time you actually asked Dr. Kearney to [redacted]?
A I did.
Q And that request was based solely on the fact that he's a very skilled surgeon?
A I agree.
Q Is that correct?
A I agree.
Q You were asked by counsel about the letter that you signed with respect to Dr. Kearney's suspension.
A Yes.
Q Did you write that letter?
A I was involved in the writing process with it.
Q Who actually wrote the letter?
A It was a joint thing within myself, Dr. Nelson, and our leadership group.
Q All right. And my -- still my question stands. Who wrote the letter?
A I don't -- I don't have -- you know, it was a group process.

Q I understand that it was a group process, and I understand that the vote was a group process. My question still stands. Who actually wrote the letter?
A I can't answer that question.
Q All right. So the letter was prepared by someone else -- you don't know who -- given to you; you read it and signed off on it, correct?
A Well, I read it. Dr. Nelson read it. Our group read and reviewed it and made the decision in terms of what it was -- we wanted to send forward.
Q But I take it, then, from your responses, and I may be mistaken, but the letter was already prepared and presented to your group with respect to a suspension; is that right?
A It was prepared in a group process, sir. That's what I can say.
Q Well, with respect to a group process, I will direct your attention -- I don't know the exhibit number that you have in that book, but it's the first minutes of the Medical Staff Executive Committee. I've got it listed as number three. And in that book --

MR. SALSBUREY: Tab 6.
MR. PAFUNDA: Number 6. Thank you.
BY MR. PAFUNDA:
Q Dr. Zachman, do you have that in front of you?
A I do.
Q If you will, number one, who recorded the minutes?
A Sarah Bentley was the recorder of these minutes.
Q All right. I take it the reason that you were acting President of the Medical Staff Executive Committee is because Andrew Bernard had recused himself?
A That's correct.
Q Dr. Andrew Bernard?
A Uh-huh (affirmative).
Q And I take it this was your first experience with the Medical Staff Executive Committee on this type of matter?
A That's correct.
Q Clinical privileges?
A Uh-huh (affirmative).
Q If you will, explain to me, why aren't the minutes signed off by someone?

A I don't have an answer for you.
Q Prior to your presentation to the Medical Staff Executive Committee, had you met with university counsel, Cliff Iler and Bill Thro?
A I met with Cliff Iler with regard to these proceedings. He was involved as a consultant to our group.
Q And I take it -- and he's listed as being present at this particular meeting, is he not?
A That's correct.
Q All right. So he was the one that, I take it, the Medical Staff Executive Committee and yourself looked to for advice on how to proceed under the UK HealthCare bylaws?
A That's correct.
Q I'll ask you, did you ever read those bylaws?
A I did.
Q All right. With respect to those bylaws, isn't there a hearing to be conducted by the Medical Staff Executive Committee under Article 9.4?
A That is kind of what is in the bylaws. And our intent from that second step hearing was to perform an independent investigation and then come together to have a hearing of the facts of the case.

Q All right.
A It wasn't meant to be, you know, a primary investigation as this one or a primary kind of hearing as this one is here.
Q But it does use the language "hearing," does it not?
A Hearing in the verbiage of that, that's correct.
Q And was Dr. Kearney afforded the opportunity to appear at that hearing before the Medical Staff Executive Committee?
A Our medical staff investigative team met with Dr. Kearney, and so the information that he had was provided to the Medical Staff Executive Committee by Dr. McDowell and Dr. Bezold.
Q That's not my question. My question is, after they finished the investigation, which we'll turn to in a minute --
A Yeah.
Q -- was Dr. Kearney afforded the opportunity to have a hearing before the Medical Staff Executive Committee?

A He did not meet with us, no.
Q So he was not afforded that opportunity?
A Correct.
Q Was there a reason why he wasn't afforded that opportunity?
A Our interpretation of the bylaws was that this was an opportunity to have an independent investigation to review the facts and present those facts to the Medical Staff Executive Committee, with the next step in the process being a fair hearing where Dr. Kearney could present his side of that story.
Q All right. And that understanding of the steps came from Mr. Iler, as university counsel, did it not?
A Well, it was a decision with myself, Kevin Nelson, Dr. Boulanger, and Cliff Iler. The four of us were together in that process.
Q So university counsel participated in that decision?
A He was a consultant to us.
Q All right. If you will, turn to your comments at that meeting on January 29, and you present to the Medical Staff Executive

Committee -- I take it it's you -- do you see the line, "Since the potential of harm to staff and patients remain substantial"? Do you see that?
A Yes.
Q Did you make that statement to the Medical Staff Executive Committee?
A This was a statement that was made, yes.
Q I didn't --
A Yes.
Q So you solely made that presentation?
A This is the presentation that I made to the staff.
Q On what factual basis did you form the opinion that Dr. Kearney presents a substantial danger of harm to staff and patients?
A It was following my conversation with Dr. Boulanger that that comment was made.
Q So as of yourself, Dr. Zachman, you had no independent factual basis to form that opinion; is that right?
A That's correct. It was out of discussion with Dr. Boulanger.
Q All right. You would agree with me that if

you wanted to demonize somebody, you would certainly say that they represent an imminent danger to patients and staff, would you not?
A That was Dr. Boulanger's assessment.
Q My question is, though, if you wanted to demonize someone, you would simply paint the picture that they're a danger to patient and staff?
A I agree.
Q All right. Thanks.
A I agree.
Q Now, the investigative team -- and I understand that this was a unique experience and that the doctors aren't lawyers.
A Uh-huh (affirmative).
Q And you had to in part rely on a lawyer for interpretation as to the legal ramifications of the bylaws, correct?
A That's correct.
Q All right. So as you move on, you appoint an investigative team that consists of Dr. Susan McDowell and the cardiologist; is that correct?
A That's correct.
Q And they're limited in their investigation,

are they not, to 14 days?
A So they were given 14 days.
Q But they're limited under the bylaws to 14 days?
A Well, I talked with Dr. McDowell and let her know that if they needed more time we could certainly afford her more time to get a complete assessment of the facts.
Q But in the bylaws, there's not extension of time, is there?
A That's correct.
Q So there's a short window to conduct an investigation, correct?
A That's correct.
Q And was Dr. McDowell, her investigative team, were they supplied materials?
A They were provided Dr. Kearney's personnel file, and they were given information and access to whomever they decided they wanted to talk to after that initial review.
Q Were they provided with his entire personnel file?
A I don't know if it was the entire personnel file or not.
Q All right. Now, with regard to Patient

[redacted]
A Yes.
Q -- they were to go out, and this is just with Patient [redacted], and interview Patient [redacted] and those who were attendant to Patient [redacted] around the time of his complaints; is that correct?
A Dr. McDowell was given free rein to conduct her investigation.
Q That was kind of the scope of her investigation?
A She made the decision to talk with [redacted], yes.
Q And you agreed that was an appropriate decision?
A Agreed.
Q She was not able to contact [redacted]; Did you know that?
A I know that she did not talk with her; that's correct.
Q She wasn't even able to contact her. Do you know when [redacted] worked at the university, her dates of employment?
A I don't have that in front of me, no.
Q Did anybody determine her dates of employment

at the university and her job duties prior to the time that the suspension was issued by the Medical Staff Executive Committee?

A I don't have that information either.

Q All right. Would you agree with me that [redacted]'s complaints, whatever they may be, were never logged into Dr. Kearney's personnel file?

A I don't have specific knowledge of that, sir.

Q Are you aware of the governing regulations that permit an employee, if a matter is placed in their personnel file that's unsolicited, negative, they have the opportunity to respond to it? You don't have to be.

A I don't know that.

Q So I take it when the investigative committee came back, your Medical Staff Executive Committee reviewed the documents that were presented; is that correct?

A That's correct.

Q All right. But that was not, if you recall, his entire personnel file, was it?

A Again, I don't know if his entire personnel file was reviewed. I don't know what's

inclusive in the entire personnel file.

Q Did you have an opportunity to review yourself, as a member of the committee, his entire personnel file?

A I reviewed parts of that file that were presented to the Medical Staff Executive Committee. I could not tell you if that was the complete file or not.

Q Now, let me ask you this question. You may not know any facts related to it, but I take it from your responses this was the first time you were ever involved in a matter where a physician's clinical privileges were suspended; is that correct?

A This was the first time I was acting in this capacity; that's correct.

Q And you had served on the Medical Staff Executive Committee for how long a period of time, Dr. Zachman?

A My appointment started in July of that year.

Q All right. And I take it, when you issued the suspension letter, you asked Dr. Kearney to remove himself from campus, correct?

A That was in the letter, yes.

Q And asked him not to have any contact with

residents or staff?

A Correct.

Q Is that punishment found in the bylaws, where you ask a tenured professor to remove himself from campus and not have any contact with students or residents? And the only reason I'm asking is because you're the acting President of the Medical Staff Executive Committee.

A That was my understanding, after review of this case with Mr. Iler, with Kevin, and Dr. Boulanger.

Q Again, legal counsel told you that the parameters of the punishment could extend to removing a tenured professor from campus and prohibiting him from having any contact with either staff, residents?

A That was the guidance we were given.

MR. PAFUNDA: Thank you, Dr. Zachman. I appreciate it.

THE WITNESS: Thank you.

MR. SALSBUREY: Just briefly redirect, sir.

EXAMINATION

BY MR. SALSBUREY:

Q Doctor, you were asked about asking Dr. Kearney to perform surgery [redacted].

A Uh-huh (affirmative).

Q Do you have any personal knowledge of -- personal knowledge of Dr. Kearney and how he handles or interacts with other patients other than [redacted]?

A I haven't seen.

Q Okay. You were asked a question about whether or not the minutes from January 29 were signed. The fact that they are not signed, they're in your binder, does that change your previous testimony or opinion as to whether or not these, in fact, are accurate copies of minutes from that meeting?

A These are an accurate copy of the minutes as were produced by me.

Q And you were asked about how Mr. Iler had supplied some initial information to your committee.

A Correct.

Q Isn't it correct, though, that you still had an independent investigation performed by Drs. McDowell and Bezold?

A Cliff provided some foundation information

from which Susan and Dr. Bezold were able to start their investigation.

Q But they did, in fact, perform an investigation of their own, correct?

A They were given full range to talk with him if they decided to and given access.

Q And they did, in fact, talk with numerous witnesses?

A That's correct.

Q One of those witnesses was, in fact, Dr. Kearney, correct?

A That's correct.

MR. SALSBUREY: All right. Thank you.

EXAMINATION

BY MR. PAFUNDA:

Q Who didn't have to give an interview if he chose not to; did you know that?

A He was given the opportunity. He could make that decision if he decided he wanted to.

Q And he elected to be forthcoming with the investigation?

A That is true. And we appreciated that as a committee.

MR. PAFUNDA: Thank you, Dr. Zachman. It was a pleasure meeting you.

THE WITNESS: Good to meet you.

PROFESSOR LAWSON: Do members of the panel have any questions of the witness? Thank you very much.

MR. SALSBUREY: Can we excuse the witness subject to, I guess, to rebuttal recall, whatever? I believe he has patients to attend to.

PROFESSOR LAWSON: I'm sorry?

MR. SALSBUREY: If we can excuse Dr. Zachman.

PROFESSOR LAWSON: Yes. Thank you.

MR. SALSBUREY: Thank you, Dr. Zachman. University will call Dr. Susan McDowell next.

(BREAK TAKEN.)

PROFESSOR LAWSON: Okay. We will proceed again. Dr. McDowell, all the witnesses who are testifying for the hearing panel today will be asked to affirm that they will testify accurately and truthfully. On behalf of the hearing panel, I ask if you will commit to do that in

giving your testimony.

THE WITNESS: I will.

PROFESSOR LAWSON: Proceed.

SUSAN MCDOWELL, M.D.,

testified as follows:

EXAMINATION

BY MR. SALSBUREY:

Q Dr. McDowell, good morning. Thank you for being with us. Can you state your name for our record, please.

A Susan Marie McDowell.

Q You are employed by the University of Kentucky, correct?

A Yes.

Q For how long have you been employed by the university?

A Since 1994.

Q Okay. What are your current positions and roles at the university?

A I am an associate professor in physical medicine and rehabilitation, so I'm a physician. I am currently chairperson of our Department of Physical Medicine and Rehabilitation, and I am the associate dean for graduate medical education and the

designated institutional official for the Accreditation Council of Graduate Medical Education for our university.

Q And you are, in fact, also a voting member of the Medical Staff Executive Committee, correct?

A Correct.

Q Can you tell me a little bit about your duties as associate dean?

A So my role as associate dean is to oversee the accreditation compliance of our 53 graduate medical education training programs here. So it's about 545, 550 medical residents, and then we add another 120 dental, pharmacy residents. I oversee not only the accreditation of the program but also the human resource aspects of the office, so on boarding residents, licensure, disciplinary actions, et cetera, as it may occur during their training.

Q So you do have experience dealing with disciplinary issues with physicians in training, correct?

A Correct.

Q And do you have any experience dealing

with --

PROFESSOR LAWSON: Speak up, please.

BY MR. SALSBUREY:

Q Do you have any experience dealing with professional issues with residents in training?

A Yes.

Q What about, you mentioned the institutional representative for -- help me out with this again -- for the ACGME?

A Yes.

Q What is the ACGME?

A The ACGME, or the Accreditation Council for Graduate Medical Education, is the -- it's like the Joint Commission of hospitals.

Q Okay.

A It's the Joint Commission of graduate medical education. So it establishes the training standards and makes recommendations on measurement tools used to deem somebody competent to graduate from a training program and outlines expectations for resources, faculty, space, patient populations, whether it's in-patient, outpatient. It in essence outlines the requirements of the training

program. My role as DIO is, if there's something not right in this institution, then I am the person they come to as the source of why.

Q And DIO stands for?

A Designated institutional official.

Q Okay. And within these -- you talk about developing or dealing with standards of competency. Is it fair to say there are core competencies developed by the ACGME?

A Yes, there are.

Q Can you describe those to me, please?

A So over the last almost ten or more years now, the ACGME decided that with the public investment of funds for graduate education that it was no longer appropriate just to say, "I know a good physician when I see one," and then let them graduate and begin to practice unsupervised. What they wanted was a better assessment of multiple aspects of what they think it takes to be a competent physician. So they define six general competencies that we assess all of our learners on in the process of determining that they are ready to practice unsupervised

medicine. So those six competencies include patient care, which also includes procedural skills for those residents that are procedurally based, medical knowledge, interpersonal communication skills, professionalism, practice-based learning and improvement, and system-based practice.

Q Is it fair to say this is kind of a change in the culture, then, in how we measure physicians in training?

A Yes.

Q And you may have said this, but did the core competencies then touch on professional behavior?

A Yes, they did.

Q Can you explain a little bit more about how that works?

A So am I allowed to look at my notes?

Q Let's just, if you can, tell me what you recall.

A Okay. So professionalism includes the ability of a provider to interact with their peers in a professional, respectful, and courteous manner. It requires them to have the patient's need supersede their need for

self, meaning they have to put their patients first. It references about documentation and accuracy of the medical record entries. It references commitment to the society, the profession that they are practicing in, whatever their specialty or subspecialty is.

Q And now on your binder there, if you will, Tab 12, if you will turn to that, please.

A Okay.

Q Are you familiar, by the way, with this document, Dr. McDowell?

A Yes, I am.

Q Can you tell myself and the panel what this is?

A So each training program specialty or subspecialty, of which there are hundreds, have a set of program requirements.

Q Okay.

A And this common program requirement is the language that is the same, regardless of which specialty or subspecialty you are talking about. So if you open up -- I'll use physical medicine and rehabilitation as an example. If you open up our program requirements, there are both bolded and

unbolded texts. The bolded text is simply the insertion of the common program requirements into the more specialty-specific PM&R requirements.

Q Are these common program requirements applied here at the University of Kentucky?

A Yes.

Q And who is responsible for applying these common program requirements?

A The individual program director for the training program is responsible for ensuring that the program applies, measures, and adheres to these common program requirements. And then my role as associate dean and DIO is to have oversight that they are indeed doing that in a manner that ensures they maintain their accreditation.

Q Do medical faculty play any role in applying these common program requirements at the University of Kentucky?

A Yes, they play a big role.

Q Okay. What is that role?

A So the requirements not only indicate who qualifies as a faculty member and who doesn't qualify as a faculty member, but it also

indicates expectations of teaching, evaluation, mentoring, and their own continued learning to teach in their own scholarly work requirements.

Q Okay. And would this include faculty like Dr. Kearney?

A Yes.

Q You are -- and we touched on this before. You are, in fact, a voting member of the Medical Staff Executive Committee, correct?

A Correct.

Q And as a member of the Medical Staff Executive Committee, have you, in fact, had occasion to investigate allegations related to a summary suspension of Dr. Kearney?

A I have.

Q Okay. Do you recall attending a meeting on January 29 of this year with the Executive Committee regarding that summary suspension?

A I do.

Q Okay. Would you turn, please, to Tab 6 in your binder? As a member of the Executive Committee, do you receive or review copies of minutes of meetings?

A I do.

Q And do you recognize this document at Tab 6 of your binder?

A I do.

Q What is this document?

A This is the Medical Staff Executive Committee minutes from that January 29, 2015, meeting.

Q And you, in fact, attended that, correct?

A I did.

Q And at the top it talks about voting members present. Just so I'm familiar and so the panel's familiar, can you briefly walk me through who these other voting members who are present, who they are?

A So Dr. Richardson is a physician, I think an internal medicine physician, who practiced primarily at Good Samaritan Hospital. Dr. Oates is chairperson of radiology. Roger Humphries, chairperson of emergency medicine here at UK. Michael Dobbs, interim chair of neurology. Myself. Darrell Jennings is the chair of pathology. Andrew Pearson was there via phone. He's the chairperson for ophthalmology. Bernard Boulanger is the CMO for the hospital. Scott Stevens, I can't remember which department he's in.

MR. PAFUNDA: Radiology.

THE WITNESS: Radiology.

A And Kevin Nelson was there in his role as medical affairs, chief of medical affairs. And then Dr. Bezold is a ped's intensivist who was there, a faculty member.

BY MR. SALSBUREY:

Q And who is Andrew Bernard there, ones who are absent?

A Dr. Bernard is a surgeon. He's also the President of the Medical Staff Operating Subcommittee for Chandler. And then Cletus Carvallo is a psychiatry faculty.

Q Okay. And at that meeting you were, in fact, appointed along with Dr. Bezold to conduct an investigation of allegations related to Dr. Kearney's summary suspension, correct?

A Correct.

Q Have you ever had any experience with Dr. Kearney before this time?

A Yes.

Q Okay. Can you tell me about that?

A So a few decades ago when I trained here, starting in 1990, my first rotation as an intern was on trauma, and Dr. Kearney was my

attending --
Q Okay.
A -- doing that rotation.
Q Any other rotations other than that one?
A No.
Q Okay. And, again, if you can refresh me, your particular specialty or area of expertise is?
A PM&R.
Q Is there any overlap between that and Dr. Kearney's area as a trauma surgeon?
A When I became faculty in '94, we shared a number of patients, trauma patients, that would then come to rehab that we would then care for together up until 2007, when I took my role as associate dean, at which point I didn't do any patients anymore, so we didn't share patients after that.
Q You did then, in fact, after that January 29 meeting, conduct an investigation, correct?
A Correct.
Q Together with Dr. Bezold, correct?
A Correct.
Q Excuse me. And you prepared a -- you and Dr. Bezold prepared a written report

following that investigation, correct?
A Correct.
Q Can you turn to page -- Tab 7, excuse me, starting at page 35 on the right-hand corner? And your report, by the way, did include an appendix of documents, correct?
A Correct.
Q Can you take a moment to look at that, and then when you've had a chance to get through it, I'd like to ask you some questions about that. Dr. McDowell, do you recognize this document beginning on page 35?
A I do.
MR. PAFUNDA: Mr. Salsburey, I've already agreed that's in. You don't have to lay any kind of foundation.
BY MR. SALSBUREY:
Q Well, is this, in fact, a copy of your report?
A Yes.
Q And an accurate one?
A Yes.
Q Dr. McDowell, regarding the scope of your investigation, if you'll look at pages 46 and 47, as they're tabbed at the bottom there,

did you, in fact, have a -- as far as policies or bylaws are concerned, what kind of things were at issue with your investigation regarding policy and bylaws?
A As part of the initial investigation, we -- we were tasked with investigating the incident relative to, was the action by Dr. Boulanger warranted and was it consistent with a violation of the behavioral standards policy. And so we were given a copy of those standards, which we already had signed that we were aware of, as sort of the foundation of the investigation and what we would be attempting to decide if indeed that policy had been violated.
Q And so these principles and commitments for behavioral standards were, in fact, kind of the umbrella over your investigation, correct?
A Correct.
Q Okay. Factually speaking, your investigation, as I see the first couple of pages of your report, included review of documents from Dr. Kearney's personnel file, correct?

A Correct.
Q And the documents included are not only listed there on the first two pages on your report but also included in the appendix, correct?
A Correct.
Q And factually speaking, your investigation also included a new matter regarding [redacted], correct?
A Correct.
Q And finally, your investigation did include an investigation of a [redacted] involving a patient named [redacted], correct?
A Correct.
Q So you conducted an investigation, you prepared your report, and you interviewed a number of folks. Tell me about how the interview process worked. In other words, how did you select your interviewees and how did you conduct the investigations in general or the interviews in general?
A So we had an initial meeting after the Medical Staff Executive Committee and just sort of reviewed the incident, the incident with the patient. And in that we were made

aware of the physician faculty involved, the resident faculty involved, the staff involved in the procedure, so that we would know who was physically present during that event. So that sort of started the list of who we were going to talk to.

Q Okay.

A And then we arranged those in an order that Dr. Bezold and I felt would be appropriate to interview. Through that interviewing process of different people, we then subsequently added a couple of other folks who we wanted to talk to. When we started -- so then the interview times were scheduled, the location was scheduled, just the logistics of getting it done were completed, and then for each interview we started with just very basic open-ended questions, "Tell us what happened," and tried to be very consistent in our questioning one interview to the next.

Q Am I correct in understanding that you had fairly open-ended questions for your witnesses, then?

A Yes.

Q And who typically was present for these

interviews?

A Myself or Dr. Bezold.

Q And the both of you or one at a time?

A We were both present for all of the interviews except for one that is noted in the report, which I was the only one present.

Q And which one was that?

A It is the interview with Dawn Profit.

Q Okay. And who is Dawn Profit?

A Dawn Profit was the nurse in the endoscopy suite.

Q And if you could point the panel as to which page you're looking at of your report.

A It's page 8 of the report, page 42 of the document, the bottom part of the page, it says, "Ms. Profit was interviewed February 4, 2015, by Dr. McDowell only." And that was because Dr. Bezold had a scheduling conflict. He was actually on call that week.

Q But otherwise, both you and Dr. Bezold were present for these interviews, correct?

A For the remainder of them we were both present.

Q In fact, you also interviewed Dr. Kearney, correct?

A Correct.

Q Did Dr. Kearney have counsel present at that meeting?

A Yes.

Q Was anyone else present at that meeting?

A Mr. Iler was present as well.

Q That is the associate general counsel at the university, correct?

A Correct.

Q We'll talk about the interviews in a minute, but before we do, you also reviewed documents from Dr. Kearney's file, correct?

A Correct.

Q At the -- and on pages 1 through 2 of your report, 35 and 36 --

MR. PAFUNDA: I'm going to object. She hasn't identified what document she reviewed.

MR. SALSBUREY: That's what I'm about to have her do.

MR. PAFUNDA: Thank you. Then I'll withdraw that objection.

BY MR. SALSBUREY:

Q Dr. McDowell, I would like you to identify, if you would, for the panel what documents

you reviewed in the course of the investigation.

A Okay. So we reviewed documents that were provided to us that were in Dr. Kearney's personnel file.

Q Okay.

A I'm going to assume it is not his entire file. It was what was provided to us at the beginning of our investigation. And in that file, there were several letters dating back to 1992 all the way through 2013.

Q Okay. And those are the ones listed on pages 1 and 2 of your report, correct?

A Correct.

Q Can you briefly walk the panel through these documents and the significance, if any, that they had in your investigation?

A So the initial document, and they're all in the appendix as well, if you want to see the original, there's a document from March of 1992 by Dr. Young, who at that time was the chair of surgery. It was -- referenced interaction with Dr. Kearney and an office member that was indicated to be rude, offensive, impolite, arrogant, and loud

behavior. We -- when we interviewed Dr. Kearney, we presented him with the content of that file that we were provided, and he indicated that he was aware that that file was in his -- that that document was in his file.

Q Okay.

A July 20, 1995, there's a letter in there referencing comments made publicly on rounds about the deterioration of an OB patient that had also sustained trauma and some concerns about the public nature of that comment and the contents of that comment as being derogatory to the OB faculty member. Dr. Kearney was also aware that that document was in his file.

Q Okay.

A There's several documents from an OR incident in [redacted]. They are from operating room nurses. They describe an incident of bantering among physicians in the operating room that included Dr. Kearney that was felt to be crude, unprofessional, loud, disruptive, inappropriate, unwelcome, unwarranted, vile and crude, inexcusable and

discompassionate verbal exchange that compromised their ability to provide care for the patient. Dr. Kearney was also aware of this document in his file.

Q Okay.

A There's a letter, in September 5th of 2000, from Dr. Young referencing the disciplinary action relative to that August incident and which requested a voluntary remediation, and it required evaluation by a mental health professional, formal written apology to each member of the surgical team, attendance to sexual harassment sensitivity conference, and five-day vacation from his medical staff duties. It also indicated a failure to meet the requirements of this voluntary remediation or acting in a similar fashion in the future would result in additional corrective action, which could include termination of medical staff privileges and termination from the university. We noted there wasn't any follow-up documentation as to whether or not the required remediation occurred, but in our conversation with Dr. Kearney, he was aware of the document in

his file, and he indicated that he did complete the required anger management course.

Q Okay. Go ahead and continue.

A July 8th, 2005, is a letter from Dr. Perman, who at that time was the dean of the College of Medicine and vice president for clinical affairs, requesting a one-on-one meeting with Dr. Kearney for report of a profanity-laced, totally-uncalled-for outburst during the care of a trauma patient [redacted]. This letter references a discussion that Dr. Perman apparently had with Dr. Kearney in December of 2004, during which, quote, Dr. Perman said, "I told you I have zero tolerance for continued inappropriate behavior on your part which demeans the entire institution." Dr. Kearney was also aware of this document in his file.

Q What about this January 2009 document?

A So there's a document in there signed by then chair and now chair Joseph Zwischenberger for Department of Surgery, Dr. McGrath, Colleen Swartz, and Paul Depriest, at that time the CMO. It was written to Drs. Karpf, Lofgren,

and Perman, indicating again that Dr. Kearney had continued to exhibit aggressive and humiliating behavior. This document appeared to be a draft document, as it has "draft" across the body of the document. There was no indication in the file what had become of the draft document or whether any disciplinary action actually took place. And so when we met with Dr. Kearney, he indicated he had only become aware of that document in his file after he was suspended relative to the more recent incident and requested a copy of his file.

Q If I can draw your attention to page 61 there within Tab 7, is that the document which we have just been discussing?

A Yes.

Q Is it possible you're thinking of another document as a draft document?

MR. PAFUNDA: I understand the draft document has "draft" posted on it.

THE WITNESS: Sorry, I may have gotten mine --

BY MR. SALSBUREY:

Q I just wanted to make sure.

A Yeah, that was my fault. I got confused. Same authors.
Q And the authors of that one were on page 61 there.
A The authors were -- sorry, of the January 2009 document?
Q Yes, ma'am.
A Was Dr. Zwischenberger, Colleen Swartz, Dr. McGrath, and Dr. Depriest.
Q Okay. Is it possible, and we'll get to this in a little bit, but if you flip to page 63, that that is the draft document you were thinking of?
A Yes, it is.
Q Okay. We'll cover that in just a moment. Okay. All right. Moving on, though, we'll finish this up and I'll move on. Go ahead.
A So the next document is a letter dated February the 5th, 2010. It's from Dr. Kearney to Dr. Zwischenberger indicating that he will voluntarily agree to the recommended remediation course, and after completion of the course, the current allegation will be expunged from the record. That's a quote. Dr. Kearney was aware of

this document in his file, and he again completed a second required course on anger management.
Q Okay. Now, the next one, the May 7, 2010, is that the draft document to which you were previously referring?
A Yes.
Q Okay.
A This is the draft document. They asked for a voluntary remediation action plan that included a referral to the Kentucky Physician Health Foundation, indicated Dr. Kearney was to contact the foundation and was advised that the recommended program would involve being away from -- when he was advised that the recommended program would require him to be away from his home for several weeks, Dr. Kearney indicated that he could not make suitable arrangements for his family to accommodate the program during the school year. There are additional amendments made to the plan. Again, it's in a draft format and no indication that the draft was ever signed and that any additional follow-up occurred. This document Dr. Kearney became

aware of only after his suspension and subsequent review of his file.
Q Did Dr. Kearney, when you interviewed him, have any information or thoughts to share regarding that draft document other than this was the first he had seen it?
A That was the only information that I remember.
Q Then there's a December 12, 2012, letter from Dr. Zwischenberger, correct?
A Correct.
Q And if I'm correct, on pages 73 through 75 of Tab 7 there, is that the document referred to there in your report?
A Yes.
Q And, likewise, if I could also flip you to Tab 1 in your binder. Is that the same document?
A Yes.
Q Okay. Tell me about your review of that document in the course of your investigation, please.
A So that was a letter from Jay Zwischenberger, chair of the Department of Surgery. It was a written reprimand and action plan regarding

unprofessional conduct summary. There are complaints by three operating room nurses regarding unprofessional conduct in the operating room. As part of this written reprimand, Dr. Kearney was required to refrain from such unprofessional conduct when interacting with other UK personnel. "Specifically, you shall not slap, smack, or touch another UK employee with whom you are angry or frustrated. In addition, you should show no" -- "not direct profane comments toward UK personnel if in your opinion they fail to perform the duties adequately." Violations of the terms of this written reprimand were subject to corrective action. The document was signed and dated by Dr. Kearney January 9th, 2013.
Q And generally speaking, what was your understanding of the underlying complaints addressed in that document?
A So based on the documentation from Dr. Zwischenberger, there were nurses in the operating room [redacted]. One of the nurses, [redacted], complained that -- alleged that a time-out was being performed.

During lunch, among other things, [redacted], the circulating nurse, called out the name of the procedure to be performed. She initially called out the wrong procedure but then corrected herself. After she corrected herself, it was alleged that Dr. Kearney smacked her on the left shoulder with an open hand. She said that it hurt and left a red mark on her shoulder. It was her interpretation that Dr. Kearney smacked her because she messed up the time-out. In response to being smacked on the shoulder, [redacted] said, "Hey, I'm pregnant," and she alleged Dr. Kearney responded, "Well, whose fault is that, yours or the guy's? Well, I guess it doesn't matter because it takes two to tango." [redacted] was very upset by those actions and those comments and began to cry. And after she completed the time-out, she was told by another staff member to take a break.

Q And in that letter from Dr. Zwischenberger -- I think you covered this already -- there was an indication that continuation of behavior addressed in there would result in further

corrective action; is that right?

A Yes.

Q Back to page 2 of your report, Tab 7, page 36 in the binder. You had one other document that I believe you reviewed, correct?

A Correct.

Q And that was?

A They are faculty performance evaluations done by residents and medical students of Dr. Kearney.

Q Okay. But there were also, as I review your appendix here, a couple other documents that aren't necessarily on your list here. If you'll go to page 45 and Tab 7. Previously you had testified that you -- I think you're referring to physicians -- have to sign off on behavioral standards, correct?

A Correct.

Q And what is --

MR. PAFUNDA: Professor Lawson, I have to take a break, two minutes.

PROFESSOR LAWSON: How much more do you have with this witness?

MR. SALSBUREY: I have a good deal more, sir.

PROFESSOR LAWSON: Okay. We can take a five-minute break. Is that what you need?

MR. PAFUNDA: Thank you.

MR. SALSBUREY: We'll start with this document when we get back, sir.

PROFESSOR LAWSON: Okay. Five minutes.

(BREAK TAKEN.)

PROFESSOR LAWSON: Proceed.

BY MR. SALSBUREY:

Q Dr. McDowell, before we took a break, we were looking at a document, page 45 to the appendix of your report. To back up, you had previously testified about a December 20 letter from Dr. Zwischenberger that Dr. Kearney signed off on in January 2013, correct?

A Correct.

Q And then on page 45 there, what is that?

A This is the acknowledgment signed by Dr. Kearney that he has received a copy of the Behavioral Standards of Patient Care Commitment to Performance and that it identifies the behaviors described that are expected of the staff and the faculty and

students for UK HealthCare.

Q And that was two or three months after Dr. Zwischenberger's letter?

A Yes.

Q And are these, in fact, the same behavioral standards that are listed at the beginning of the appendix to your report that you were looking at in this investigation?

A Yes.

Q So you also reviewed that record. Did you also review some records regarding [redacted] and a complaint from her?

A I did.

Q And if you would turn to page 83 of your appendix, Tab 7 there.

A Okay.

Q And do these -- from 83 to 86, are these, in fact, the records regarding [redacted] that you reviewed?

A Yes, they are.

Q But you did not personally communicate with [redacted] over this, correct?

A Correct.

Q Did you attempt to contact her?

A Yes.

Q Tell us about what you did to attempt to contact her.
A The attempt to contact her was made through UK legal office. We were not able to get her to respond to our request to be interviewed.
Q Okay. To your knowledge or based on your review of the record, did she speak with anyone at the university?
A My only knowledge of her speaking to anybody at the university is relative to the documents that are in the appendix.
Q That would include Mr. Iler per letter, correct?
A Correct.
Q And Ms. Bender with e-mails, correct?
A Correct.
Q You interviewed [redacted] in the course of your investigation, did you not?
A I did.
Q That is reflected with the stamp numbers pages 42 through 43 in Tab 7 of your report, correct, pages 8 and 9 of your report?
A Correct.
Q Can you tell me, as the investigator, what your understanding of the issue was with

[redacted]?
A My understanding of the issue with [redacted] is that he was a patient who had been injured, had a cervical level spinal cord injury, so he had limited use of his arms, no use of his legs. He was preparing to be transitioned to do rehab and was having issues with his swallowing. So in an effort to get the feeding tube out of his nose, the decision was made to [redacted] [redacted], and then he could be transferred to rehab.
Q Okay. [redacted] had complaints about particular things that he says Dr. Kearney said to him, correct?
A Correct.
Q What were those things that he said to him as communicated to you?
A So we interviewed [redacted] by phone on February 5th, 2015. He, again, affirmed our history that we were aware of that he was quadriplegic from an accident, that he had been cared for at the University of Kentucky, and that he had undergone a [redacted]. We asked him, again, the same open-ended

question: Tell us what happened about the procedure. And so he indicated that he was initially asleep and then woke up as they began to attempt [redacted]. He says at that point that he became aware of a lot of people around him, including Dr. Kearney with the residents. He stated the resident was attempting to [redacted], which he was fighting. He states that he remembers Dr. Kearney talking to the resident, telling him to, quote, hurry up. He states the resident then said that the patient was awake and was fighting him. At that point he heard Dr. Kearney say, "Pry his F'ing mouth open." [redacted] -- excuse me, [redacted] then states he asked to be put back to sleep, at which point he said Dr. Kearney responded, "We do not put you to sleep for this, you F'ing idiot." [redacted] asked again if he could go back to sleep and was told, "No, we do not do that." And at that point he just stopped fighting -- Indicates he stopped fighting and allowed the [redacted]. He does remember Dr. Kearney asking the staff

what had been given to him, at which point he remembers Dr. Kearney responding, "50 is not enough." He remembered Dr. Kearney instructing the resident to "make the F'ing incision," to which the resident responded, "He is awake." [redacted] states that Dr. Kearney responded, "He cannot feel it. He is an F'ing quad." Shortly after that [redacted] indicates he fell asleep and does not remember any of the remainder of the procedure. [redacted] indicated that at some point later he was told -- he told his mother what had happened and that he did not wish to have Dr. Kearney back in his hospital room. [redacted] indicates a couple of days after the procedure Dr. Kearney came to the patient's room and apologized, saying Dr. Kearney was not yelling at [redacted] but was just trying to get the [redacted] in place because he knew he wanted the tube out of his nose and that he wanted to start eating. Dr. Kearney indicated at that time to [redacted] that he would get him some sort of food. [redacted] asked Dr. Kearney to get out -- "Get out. Mom will be pissed," to

which [redacted] indicates Dr. Kearney said, "She is not here. I just told her you will never walk again." [redacted] indicates that his experience during the [redacted] made him "scared to have anything done at UK."

Q Okay. You also talked to [redacted] about an incident that happened outside of his room a few days prior, correct?

A Correct.

Q Just kind of to the point, what does he allege that Dr. Kearney said about him?

A He indicates that Dr. Kearney referred to him as an "F'ing quad."

Q Okay. But [redacted] was not the only person you interviewed, correct?

A Correct.

Q You also interviewed Dr. Boulanger, correct?

A Correct.

Q And he will testify later, so I don't want to belabor the point, but there was a particular piece of equipment that Dr. Boulanger had told you kind of secondhand [redacted] said he recalled being used, a bite block. Can you tell me about that?

A So prior to passing the endoscope, they put a

circular bite block in the patient's mouth so that they can't bite on the scope. It in essence blocks their teeth. And so Dr. Boulanger indicated that [redacted] also recanted or -- or retold the story of having the bite block placed and having issues getting his mouth open and him trying to bite the scope and the comments that were made.

Q Did you have an understanding from that discussion with Dr. Boulanger what the color of the bite block supposedly was?

A I believe it was green.

Q Okay. That would be indicated in your report regarding Dr. Boulanger, correct, if I looked on page 4 of your report, page 38 in the first paragraph?

MR. PAFUNDA: Mr. Salsburey, you can show her. I don't care.

MR. SALSBUREY: Thanks, Bernie.

MR. PAFUNDA: You're welcome.

A Yes.

BY MR. SALSBUREY:

Q Okay. You also interviewed [redacted], did you not?

A I did.

Q Who's [redacted]?

A [redacted] is the patient care manager for the surgical ICU and the surgical patient care beds.

Q And your interview with her is reflected on pages 5 and 6 of your report, correct, 39 and 40 in the tab?

A Correct.

Q There were -- it appears [redacted] made multiple inquiries about [redacted]'s mother; is that correct?

A She made several comments.

Q Okay. What is the significance, if any, to you as the investigator of her having several comments or inquiries regarding [redacted]'s mother?

A So as we processed through our interviews, the document is written in the order of the interviews.

Q Okay.

A So she indicated that the mother had talked to a lot of other staff on the floor and to the customer specialist. She met the customer relations specialist on multiple occasions relating to patient care issues.

Q Okay. And did you investigate or look into whether or not [redacted]'s mother did, in fact, make multiple complaints on patient care issues?

A Yeah. So when we were made aware of that comment, we wanted to get a sense for ourselves, was this one complaint? Was it 15 complaints? What were the issues raised? And so we -- we knew a complaint had been filed with the customer relations specialist relative to the [redacted]. So when we called the customer relations specialist, we not only asked him about that known complaint that we had a copy of, but we also asked him about documentation of any other complaints by this mother relative to this patient. And when we spoke with the customer relations specialist, she indicated that there was one other documented incident in which there was -- the mom was apparently sleeping in the ICU hall area or waiting room area at a time when the area was closed and not supposed to be in there.

Q And those two, if you look at page 3 of your report, page 37 in your tab, those two

complaints are reflected in your report, correct?
A Correct.
Q And those were the totality of complaints you learned about upon your own inquiry, correct?
A Correct.
Q You also interviewed [redacted], a medical student, did you not?
A I did.
Q From interviewing [redacted], what was your -- what did you learn about what, if anything, Dr. Kearney said to residents during [redacted] [redacted]?
A He indicated that Dr. Kearney was cursing at the residents during the procedure as Dr. Kearney attempted to guide them through the required steps. He did not remember the exact words that were said because he was focused on his attempts to do his portion of the procedure, which was to anesthetize the skin and make the incision for the [redacted]. He did also indicate that he remembers Dr. Kearney telling the staff and the residents to hold the patient's arms still during the procedure, and then he

recalls that cursing by Dr. Kearney during these instructions was largely directed at the residents and not at him, the medical student.
Q But he did inform you or testify as to cursing at the residents, correct?
A He did, yes.
Q You also interviewed Caitlyn Rice, correct, also, on page 6 of your report?
A Correct.
Q From talking with Caitlyn Rice, did you learn anything about the patient's, [redacted]'s, history of substance use or substance abuse, if any?
A So Caitlyn is the endoscopy tech in the room, so she preps all the equipment and in essence helps manage the procedure from an equipment standpoint. She spent the majority of her time during the procedure at the head of the bed with the patient. She noted that the patient was experiencing some discomfort. She noted that there were initial difficulties in opening his mouth and getting the endoscope passed. She does remember that some medication was provided, but she does

not know what that medication was.
Q But she does recall him being awake for the majority of the procedure, correct?
A She indicated the patient was awake for a majority of the procedure, including the initial placement of the green bite block.
Q Okay. And did Ms. Rice tell you -- she did, in fact, tell you that additional medication had to be administered to this patient, correct?
A Correct.
Q What did she say about the patient's eyes during the procedure, open, closed?
A She said that for the vast majority of the procedure his eyes were open the whole time, until the very end, at which point he relaxed. She indicated he looked distressed during the procedure.
Q What did she say with respect to what, if anything, Dr. Kearney was saying to the residents during this procedure?
A She indicated that Dr. Kearney was yelling at the residents, including calling them names, like "dumb" and "retarded." She remembered comments being made to the nurse in the room

about the patient's prior [redacted] history. She also remembers Dr. Kearney saying, quote, stuff to the patient that was very unprofessional and it included profanity, but doesn't remember his exact words.
Q And in fact Dr. Kearney, when you interviewed him, also told you about information about the patient's [redacted] history, correct?
A Correct.
Q And we'll get to that in a little bit. But you did, before interviewing Dr. Kearney, interview a resident named Justin Peterson, correct?
A I did.
Q What did Justin tell you with respect to the issues or discussions about the patient's tolerance to medication?
A So he -- Dr. Peterson remembered that shortly after the patient was wheeled into the room there was a conversation about what medications should be given to the patient given the fact that [redacted], quote, and this is Dr. Peterson's words, [redacted].

Q Just for my benefit here, what does that mean?

A [redacted]

MR. PAFUNDA: Professor Lawson, Dr. McDowell just said he would require a larger dose. My question is what drug?

BY MR. SALSBUREY:

Q Did you have an understanding what drug was being administered to [redacted]?

A I don't know which benzodiazepine they were using.

Q Okay. Justin, Dr. Peterson -- excuse me -- did recall [redacted] being more awake than usual compared to others in [redacted] he had done, correct?

A Correct.

Q What was Dr. Peterson's recollection when [redacted] asked to be put to sleep? What

was said or done?

A He remembered Dr. Kearney responding directly to the patient using, quote, a derogatory term, which in essence indicated in Dr. Peterson's opinion that he was not going to put him to sleep for the procedure. He, despite prompting on multiple occasions, could not remember the exact words that Dr. Kearney used, and he didn't remember if additional medications were given.

Q Let me ask you, frankly, having sat down with Dr. Peterson, what was the issue of recall or reluctance on his part?

MR. PAFUNDA: I'm going to object. That calls for speculation. Even though we don't have rules of evidence, we don't have mind readers.

PROFESSOR LAWSON: I think I'll overrule your objection. Let her answer the question.

BY MR. SALSBUREY:

Q Go ahead.

A Neither one of the residents would be very specific with the terms used.

Q Okay. Did Dr. Peterson hesitate at all

before he answered the question about what terms were used?

A I asked him to be specific.

Q Okay.

A And he just would not be specific.

Q Okay. But Dr. Peterson also told you that there was a lot of cussing and name calling throughout the procedure; is that correct?

A That's correct.

Q And he also told you that later in the procedure additional medication did have to be given to [redacted], correct?

A Yes.

Q And you did interview Dr. Kearney, correct?

A Yes.

Q And in fact, Dr. Kearney was your final interview of your investigation; is that right?

A Correct.

Q Is that reflected on pages 9 through 10 of your report?

A Yes.

Q Dr. Kearney, it's reflected at the beginning of that section, gave you some background information on the patient. Can you tell us

what that is?

A So Dr. Kearney was interviewed on February the 5th, 2015. He remembered the patient well, indicating that he was riding a scooter when he was hit by a vehicle, which Kearney stated that the patient was, quote, [redacted] with [redacted], unquote, and had [redacted], meaning the patient's mother. He indicated there were multiple interactions with the patient's mother, but he never saw any of the patient's significant others.

Q Dr. Kearney did agree or confirm others' testimony that the patient did ask to be put to sleep during that procedure, correct?

MR. PAFUNDA: Mr. Salsburey, you can show her.

MR. SALSBUREY: Thank you.

THE WITNESS: Sorry, I just want to be accurate.

MR. SALSBUREY: I'm trying to --

THE WITNESS: Yes.

BY MR. SALSBUREY:

Q Okay. That is correct, yes?

A That is correct.
Q If you look a little further down the page, Dr. Kearney did, in fact, admit to you that he did call [redacted] -- say "Hey, dumb ass, we are trying to help you, just relax," correct?
A Correct.
Q Dr. Kearney also admitted to you he would be harsh on the residents, correct?
A That's correct.
Q And he could, quote, almost guarantee I used profanity, unquote, correct?
A Correct.
Q And that he likely yelled, correct?
A Correct.
Q And he did go and apologize to [redacted] the next day, correct?
A Correct.
Q He also told you that he tries to go light on sedation in those procedures like this [redacted], correct?
A Correct.
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.
MR. PAFUNDA: Share what?
BY MR. SALSBUREY:
Q He never made any mention of retaliation from the administration regarding discussions of practice plan at UK?
A Not to my recollection.
Q Okay. And it's certainly not reflected in your report either, correct?
A Correct.
Q I want to kind of switch your hats here because you investigate, but you're also a voting member of the Executive Committee, correct?
A Correct.
Q And there were the behavioral standards you were dealing with, and previously you had testified about you're familiar with

behavioral standards and also work that you do as the CIO regarding core competencies with the ACGME. First of all, with the behavioral standards you were looking at in this investigation regarding interaction with patients and staff, what is the significance to you as a member of the Executive Committee of that proper behavior toward patients as far as patient care goes?
A I think the -- whether I'm a member of the Medical Staff Executive Committee or whether I have my associate dean DIO hat on, the issue relative to professionalism and interpersonal communication skills is they are there to assure that things are handled and communicated effectively because the literature has shown that failure to do so or to have unacceptable behavior or inappropriate behavior or disruptive behavior increases the risk of medical error, increases the risk of adverse patient events, decreases patient satisfaction, and increases the likelihood of turnover of qualified staff who don't want to work around that kind of behavior.

Q Is there a correlation between the behavioral standards at issue in your investigation and the kind of professionalism competencies you were telling me about with ACGME?
A No, they are varied.
Q Okay. Same principles in place, then?
A Same principles in place.
Q Okay. As a practical example, if you can help me, if there is name calling of staff, be it residents, nursing staff, whatever, going on, what kind of impact can that have on the training of the staff or residents?
A Well, it would provide them an example that is inconsistent with the accreditation standards of acceptable behavior for them to be a competent, unsupervised physician.
Q And as you testified earlier, there's kind of been a change in cultural focus of what it takes to be a physician, correct?
A Yes.
Q Okay. Practically speaking, what kind of -- well, can unprofessional behavior, name calling of staff or patients, have an impact on patient care?
A Yes.

Q Can you give me an example?
A Again --
Q Hypothetical.
A Again, the literature supports that that environment, that type of behavior increases the risk of medical error or patient safety because it prohibits or limits other individuals from maybe stepping up or saying things that may prevent something adverse from happening.
Q So hypothetically, a physician tells a nurse, "Why don't you go and put a colonoscopy bag on your head because you have shit for brains," would that be appropriate?
A That would be consistent with inappropriate behavior.
Q And what kind of an effect could that possibly have on staff, being recipients or witness to such comments?
A That that staff member would be uncomfortable in speaking up in any future incidents that may result or could have prevented an adverse patient event. It also could result in that staff member leaving the institution because they don't like the environment they're

working in.
MR. SALSBUREY: Okay. That's my questions, Professor.
PROFESSOR LAWSON: Mr. Pafunda, are you ready for cross?
MR. PAFUNDA: Yes, I am.
PROFESSOR LAWSON: Proceed.

EXAMINATION

BY MR. PAFUNDA:
Q Dr. McDowell, we met in my office, and that was when you interviewed Dr. Kearney; is that correct?
A That's correct.
Q And Cliff Iler, university counsel, was present with you?
A Yes.
Q And the other doctor --
DR. KEARNEY: Bezold.
A Dr. Bezold was there as well.
Q And the interview lasted approximately 30 minutes; is that correct?
A Yes.
Q And you didn't ask him any questions -- of course, you didn't know at the time that Dr. Karpf had threatened to fire him, did

you?
A No, I did not.
Q Did you learn that later?
A I was made aware of other issues. I don't think the words "Dr. Karpf was threatening to fire him" were part of that. I think I was made aware of another potential lawsuit or lawsuit that is currently being dealt with at the university.
Q And that's Dr. Kearney's whistleblower lawsuit?
A Yes.
Q Who made you aware of that, and when did they make you aware of that?
A I guess the day after or the week after it was filed.
Q Well, it was filed, if I recall correctly -- I'm just doing this from memory -- I'll say around February 13th. And who brought the -- February 13th of this year. So that was approximately right after your interview of Dr. Kearney. Who brought you that information that he filed a lawsuit?
MR. SALSBUREY: I'm objecting to the extent he's asking about

communications between university counsel and members of the Medical Staff Executive Committee, in the course of giving or receiving legal advice that would be privileged. But if he's asking about something else, so be it.
MR. PAFUNDA: I don't know if that is privileged.
PROFESSOR LAWSON: Just a minute. I'm going to overrule the objection because we don't have the evidence rules here, so I'm going to overrule the objection.

BY MR. PAFUNDA:
Q You're leafing through that binder that's been provided to you. Is there some communication or something in that binder that would jog your memory?
A I was just making sure I had the dates correct. I don't want to make a miscomment because I got the dates confused.
Q Who advised you that he had filed a whistleblower lawsuit?
A It was after my interview with him and after

the subsequent meeting of the Medical Staff Executive Committee and the decision to uphold the summary suspension, so it was after all of that.

Q All right. And an individual brought you that information?

A It was a conversation with Mr. Iler.

Q All right. And was it triggered by the fact that that conversation -- that conversation by the fact that Dr. Kearney had filed a whistleblower lawsuit?

A I think we were actually dealing with the GME issue, a resident issue, and I just happened to be in a meeting with him and he indicated that that had also happened.

PROFESSOR LAWSON: Excuse me, Mr. Pafunda. Let me get the record clarified on one thing. When was your lawsuit filed, what date?

MR. PAFUNDA: I don't know, approximately. I don't have a copy of it with me, but I'm going to say it was after, as Dr. --

PROFESSOR LAWSON: Was it after the professional review action letter

went out --

MR. PAFUNDA: That's correct.

PROFESSOR LAWSON: -- on February 10?

MR. PAFUNDA: Yes.

PROFESSOR LAWSON: It was filed after that?

MR. PAFUNDA: Yes, because you can only file it during reprisals.

PROFESSOR LAWSON: Okay. Let the record show that.

MR. PAFUNDA: Doctor, I'm going to show you part of my PowerPoint. May I approach?

PROFESSOR LAWSON: Yes.

BY MR. PAFUNDA:

Q And you mentioned, in response to the questions by university counsel about resident training, how they're trained, so on and so forth. If you would, read into the record -- it's already been introduced to the panel in terms of a PowerPoint -- the teaching awards that Dr. Kearney has received over the years.

MR. SALSBUREY: The university will stipulate Dr. Kearney has received

those awards.

MR. PAFUNDA: I want it read in the record.

PROFESSOR LAWSON: Go ahead. Read it into the record, please.

A There are 29 teaching awards, eight Ward O. Griffen Awards, Professionalism, one Gordon Hyde Award, Professionalism. One School of Nursing for Teaching Excellence. Two Off-Service Teaching Attending Awards, EM. I assume that's emergency medicine. Richard Schwartz Leadership in Education, 2012 Professionalism and Leadership. And then four invitations to, quote, hood medical students at graduation.

Q And would that record, in and of itself over the years, support the opinion that he is excellent in the area of teaching?

A Yes.

Q All right. And if you will, because you mentioned and you touched upon it and it has to do with rules and regulations about behavior, but what about patient care? Richard Schwartz, that award, were you familiar with Dr. Schwartz?

A I knew who he was, but I had not ever worked with him.

Q Did you know in his case there was a failure to diagnose cancer?

A I'm aware of that situation, yes.

Q All right. In that case, wouldn't it be appropriate punishment for the physician who failed to diagnose that cancer to have their privileges suspended? In fact, I'll phrase it this way. Doesn't that failure to diagnose cancer fall below the standard of care?

A I would think for that particular case, yes, that is below the standard of care.

Q And wouldn't it, since it directly impacts patient care, wouldn't it be a reasonable discipline to remove that physician's clinical privileges?

A No, not in my opinion.

Q All right. And I'll be gracious enough to ask you, why not?

A Well, because we all carry malpractice insurance for a reason. If we lose our practicing privileges every time we make a mistake, then we would not have any doctors

working.
Q But we're not just talking about a mistake because a mistake isn't where one falls below the standard of care. But you're not saying insurance impacts with patient care, are you? Because that almost sounds like a lawyer advertisement in a way.
A Well, I would just hope as a physician that if I made one error my entire career would not be flushed down the toilet.
Q All right. Now, with respect to [redacted], you reviewed this record of Dr. Kearney. Were there any other patient complaints over the 27 years that have been lodged against Dr. Kearney?
A I was not provided with any information that would say there were or there weren't.
Q So as far as you know based on your investigation, there was only one patient complaint; is that correct?
A The only one that I investigated was [redacted]'s.
Q And if there were other patient complaints that rose, let's say, to the level of [redacted], they would certainly be placed in his

personnel file; would they not?
A I don't know the answer to that.
Q I'll show you -- and look at these carefully because I believe these are the documents you provided to me when you came to my office.
A Okay.
MR. PAFUNDA: May I, Professor Lawson?
PROFESSOR LAWSON: Yes.
BY MR. PAFUNDA:
Q And I believe as you look through these -- make sure they're all there. Okay? As you look through these, you've already provided those to the panel.
MR. BEAUMAN: If I may, can we look?
MR. SALSBUREY: We've already got them. We can turn to them ourselves.
PROFESSOR LAWSON: I think these are in her report, aren't they?
MR. PAFUNDA: They are. I just wanted to make sure they are the same ones I was given in my office, and I don't want to mislead the witness, so I just want to have her review those.
A Yes, they are the same.

PROFESSOR LAWSON: For the benefit of the panel, these records are all those that are under document seven here, right?
MR. PAFUNDA: That is correct.
BY MR. PAFUNDA:
Q If you will, look at the document that's got "draft" written all over it.
MR. SALSBUREY: Page 63 in the binder.
MR. PAFUNDA: I'm just having her look at the document provided to me.
BY MR. PAFUNDA:
Q Do you see that?
A Uh-huh (affirmative).
Q If you'll look on the second page of that document, you'll see where they asked Dr. Kearney to resign from the position; am I correct? If you find it, you can read it.
A It says, "You have recognized and accepted responsibility for your behavior, and we agree to amend the February plan as follows: One, you are removed as director of trauma services."
Q Thank you. Was he removed as director of trauma services?

A I don't know.
Q All right. If I tell you that he was not, then that document at least in that portion would be inaccurate, would it not?
A That would be correct.
Q And likewise, I pose this question to you because I wonder if you raised it to the person who provided you with the document. That's a draft document. Why is a draft document that is not accurate in Dr. Kearney's personnel file?
A Which is exactly what we asked and which is why we wanted to interview Dr. Kearney so that we could sort of at least get his side of why is this here? what happened? is this real? was it ever delivered? are you aware of it? et cetera.
Q And that was the reason for my question because months ago, back in February, that's the feeling I got from the tentative questions. But my question is, who supplied that document to you and why was it in his personnel file?
A The document -- that pack of documents was supplied to us by the legal office, and I

have no idea why it was in his file.
Q All right. But I take it -- because when you were in my office, there was a question about it and you asked Dr. Kearney about that document. Did you raise a question with legal why that document was in the packet?
A No.
Q But it did strike you as odd?
A It did, yes.
Q And then when you asked Dr. Kearney if he'd been removed from that position or stepped down from it and he said no, that even struck you as something's not right here, correct?
A I didn't ask him if he was removed from that position. I asked him if he was aware that that document was in his file, and he said he was not, along with, I think, one or another document that was in his file.
Q Correct. And, if you will, and I don't have them in front of me, there's, I believe -- I may not be pronouncing his name correctly -- there's a Dr. Milligan correspondence, OB/GYN, back in 1992.
DR. KEARNEY: '94 or '95.
MR. BEAUMAN: Page 49.

MR. SALSBUREY: Page 49 in the binder, yeah, 1995. Bernie, does that sound right?
MR. PAFUNDA: I'm just doing it from memory. Yes, it does.
BY MR. PAFUNDA:
Q Was it in that packet?
A I am not -- yes, here it is.
Q All right.
A I am not the one that finds all the stuff in the house.
Q If you can see my place, no, I'm not either. Am I saying his name correctly, Dr. Mulligan?
A Yes.
Q All right. And that's his letter. What about Dr. Kearney's response to that letter? Were you provided with Dr. Kearney's response?
A Not to my recollection.
Q And if you had been, you would have provided that to me at the meeting; is that correct?
A That's correct.
Q And likewise, just from the tenor of that letter, you can ascertain or anyone can ascertain that that letter concerns patient

care, does it not?
A It does.
Q And so to bring it full circle, you were provided with selected documents from Dr. Kearney's file by university counsel; is that correct?
A That's correct.
Q You were not provided with his entire record; is that correct?
A I would assume his entire record is much bigger than this, having been a faculty member for as long as he has been.
Q And, likewise, you were not -- just to follow up on that, you were not provided with his performance evaluations, were you?
A Only that same goal set -- a few pages but not his entire portfolio of performance evaluations.
Q Before we get to the performance evaluations, if you will, turn to the document, the 2013 document that Dr. Kearney signed, and I will call it the written reprimand.
MR. SALSBUREY: That was page 70 through -- excuse me -- 73 through 76 in the binders?

(SOTTO VOCE DISCUSSION.)
BY MR. PAFUNDA:
Q You were provided -- the reason I'm doing this, Dr. McDowell, is not to aggravate you or aggravate me, but to step back in time to February 5th, which was the date you interviewed Dr. Kearney, correct, in my office?
A Correct.
Q So the materials you had at that time, not what's been provided subsequent to that, was that particular written reprimand which he signed in January of 2013, correct?
A Correct.
Q If you will look at the last sentence on the first page of that written reprimand, would you read it into the record, please?
A "I hereby acknowledge that I received a copy of this" --
Q No, no, I mean on the first page.
PROFESSOR LAWSON: Which paragraph?
MR. PAFUNDA: The last paragraph, the last sentence, I believe.
PROFESSOR LAWSON: Right here.
A "The only material discrepancy between

[redacted]'s account and your memory of this incident is that you do not recall smacking [redacted] on the shoulder. Based on the information gathered regarding this incident, I find [redacted] credible and I believe that the smack on the shoulder did occur."

BY MR. PAFUNDA:

Q Is that it?

A That's the end of the page.

Q Did you know that there was another document that said, with respect to that last sentence, that no witnesses -- there were no witnesses to the incident?

A They don't match.

MR. PAFUNDA: No, they don't match. That's my point.

(SOTTO VOCE DISCUSSION.)

BY MR. PAFUNDA:

Q Do you know why they don't match?

A No.

Q Okay. Thank you.

A I guess you can't put a head nod in the transcript.

Q I got the head nod. The document you

presented was unsigned by Dr. Kearney; is that correct? Or was it signed?

A The --

DR. KEARNEY: In the packet.

A In this packet, the original document is unsigned.

MR. PAFUNDA: All right. I haven't provided the panel members with a copy, but I'd like to do so now and mark that as Dr. Kearney's Exhibit Number 1.

MR. SALSBUREY: Let the record show that that unsigned one also appears in her appendix as pages 70 through 72.

MR. PAFUNDA: Well, I didn't know.

PROFESSOR LAWSON: It's already in here.

MR. SALSBUREY: Both signed and unsigned versions.

BY MR. PAFUNDA:

Q If you will, the documents do not match, as you just announced to the panel, correct?

A Correct.

Q But you were supplied with that document by whom?

A Legal counsel for the university.

Q Mr. Iler?

A Mr. Iler.

Q Thank you. If you will, take a moment and read that document, either the signed one or the unsigned one, because it has the pronoun "I," but if you read the first paragraph on the first page, it would be -- who was conducting the investigation?

A I'm sorry. You're going to have to ask that again.

MR. PAFUNDA: All right. Dr. Kearney needs a break.

DR. KEARNEY: 30 seconds.

PROFESSOR LAWSON: Does he need to be in here while you proceed?

DR. KEARNEY: No, I do not.

MR. PAFUNDA: He doesn't think so, but I think he should be. This is too important.

PROFESSOR LAWSON: Okay. We'll take a break. If anybody else needs to do something, well, they can take five minutes.

(BREAK TAKEN.)

PROFESSOR LAWSON: Mr. Pafunda, you can

proceed.

MR. PAFUNDA: Thank you.

BY MR. PAFUNDA:

Q Dr. McDowell, my point is -- and you would agree with me, would you not? -- it appears, number one, Dr. Kearney's personnel file has been doctored; is that correct?

MR. SALSBUREY: Object to form.

THE WITNESS: It's not consistent. There appear to be inconsistent documents.

BY MR. PAFUNDA:

Q All right. And likewise, when you were given documents to conduct your investigation, you were given those documents by university counsel and they were -- correct?

A Correct.

Q And apparently university counsel culled just a few documents from Dr. Kearney's personnel file; is that correct?

MR. SALSBUREY: Objection to the form.

PROFESSOR LAWSON: Sorry?

MR. SALSBUREY: Object to the form of the question, but I'm not asking her not to answer.

PROFESSOR LAWSON: Go ahead and ask the question.

BY MR. PAFUNDA:

Q A few documents were culled from Dr. Kearney's personnel file?
A That's what it appears to me.
Q Yes. And in all fairness, you were only given a brief period of time, 14 days, to conduct your investigation, correct?
A Correct.
Q And likewise, I take it this was the first such investigation you had done on behalf of the Medical Staff Executive Committee?
A On behalf of that committee but not my first investigation of a disciplinary action.
Q No, I know that from your earlier response. I'm just talking on behalf of the committee.
A Correct.
Q All right. And I take it university counsel provided you guidance in regard to that investigation, number one, like the time frame, correct?
A I was aware of the time frame, yes.
Q On your own?
A I knew when the next scheduled meeting was

but was told that I could have as much time as I needed.
Q All right. Did you know that the bylaws state that it has to be conducted within 14 days?
A I was aware that the bylaws say that. I was also aware that we could have asked for an extension if I needed it.
Q Correct. You're also aware of the fact that the bylaws called that Dr. Kearney have an opportunity for a hearing in front of the Medical Staff Executive Committee?
A I'm -- I'm not -- I'm hesitating because of -- I don't know those bylaws as well --
Q All right.
A -- as to what the content is, yeah.
Q That's fair. If there was a question about the bylaws or the procedures, who would answer that question?
A Either Mr. Iler or Dr. Nelson.
Q Not Dr. Zachman, the acting president?
A He would have been a part of the discussion, as well as the acting president.
Q But I take it with respect to how the bylaws operate, what's to be done, it would be the

responsibility of counsel for the university, correct?
A Correct.
Q If you will -- and you can use their notebook and get away from the documents you provided me. Your investigative report, you interviewed, as you've already told the panel, a number of individuals, correct?
A Correct.
Q Did you check [redacted]'s medical records prior to or at any point during your investigation?
A I did not.
Q All right. Do you know how long he was at the hospital before he had the [redacted]?
A I do not.
Q Do you know his condition when he went into the endoscopy suite, his physical condition?
A I do.
Q All right. And that was?
A He was quadriplegic.
Q Oh, I know that, but other than that, complications associated with his [redacted], for example, breathing?
A Okay. So I have a subspecialty certification

in spinal cord injury medicine, so you can say [redacted] to me and I know exactly what he looks like. But there were no conversations about his current stay and what complications he had had or not had, et cetera.
Q So you and I are on the same track. All right. [redacted], I have not seen his medical records, so I don't know if that's the precise location, but I'm assuming that it is, and you agree with me, correct?
A I just knew he was a [redacted] injury.
Q And likewise, I take it from mid-chest down he had no feeling?
A I don't know if he had a complete or incomplete injury.
Q If I tell you it was a complete injury, it would be true he would have no feeling from the mid-chest down?
A That is more than likely correct.
Q And that would be consistent with your earlier description that his legs weren't functional; is that correct?
A That's correct.
Q All right. But he did have some movement with respect to his arms or shoulders; is

that correct?
A That's correct.
Q All right. That's your understanding that you've gleaned from whom?
A From my conversations with all of the folks that we interviewed.
Q All right. Now, with respect to the folks that you interviewed, you did not interview Dr. Ross Strong, who was also present in the suite during the [redacted], did you?
A That is correct.
Q And was there a reason why you did not interview Dr. Ross Strong?
A We were given a different name by Dr. Peterson and then given Dr. Strong's name by Dr. Kearney, so we weren't sure which other resident was in the room.
Q I'm not faulting your investigation. It just jumps off the page, if Dr. Strong was in the suite, he wasn't interviewed. And I knew from our conversation in the office at the time you had been given misinformation about who was there.
A Dr. Bezold and I discussed the value of interviewing one of -- figuring out who that

other resident was in the room, how long were they in the room, and determined that we had heard the same sequence of events from everyone that we interviewed in the room and that we didn't feel hearing it again from another learner was going to dramatically change the evidence in the report.
Q And plus, that night, [redacted], that night the Medical Staff Executive Committee was meeting; and that's when they voted, based on the information you supplied, to suspend Dr. Kearney's clinical privileges?
A That was not part of our decision-making.
Q No, no, I'm not saying it was part of your decision-making, but they coincide in time. [redacted] you learned from Dr. Kearney that Dr. Ross Strong was in the suite. That night you had a meeting, the Medical Staff Executive Committee, correct?
A That is correct.
Q All right. And that's when they voted?
A We knew there was another learner in the room for a period of time the morning of the 4th and decided not at that point to figure out exactly who that learner was but to go with

our planned set of interviews and then decide if we felt like there was anyone else that we needed to talk to. And by the time we had gotten to Dr. Kearney, we were comfortable that we had heard the similar story pretty much every time, that talking to someone else who might have been in the room would have added no value to our report.
Q All right. I'm not faulting you for that. But likewise, with respect to what happened a couple of days before when Dr. Kearney was in the patient's room and [redacted] complained that at that point, which you note in your investigation, that he called him a "fucking quad" while he was at his bedside, did you try to learn who the female resident was that accompanied Dr. Kearney?
A No.
Q Did you know that the female resident was Dr. Caroline Neff?
A I did not.
Q If you had known it at the time -- and again, I'm not faulting your investigation. If you had known it at the time, would you have interviewed her? Maybe, maybe not?

A Maybe, maybe not. That incident was to us not our primary focus.
Q May I ask why not? Because, you know, if you're in a patient's room, you're a physician, you look at a patient who's quadriplegic, and you say "You're a fucking quad," that's pretty drastic; is it not?
A I would say yes.
Q All right. Why wasn't that a part of the focus of your investigation?
A It -- I think we were comfortable with the information that had been provided from the patient --
Q Uh-huh (affirmative).
A -- that the words were said. The only question was why were they said. Were they directed at the patient? Were they directed as teaching to the resident? Did they occur at the bedside? Did they occur out in the hallway? We were comfortable that the words were said.
Q All right. If you recall from your investigation, you had [redacted]; you interviewed her. She was a patient care manager, correct?

A Correct.
Q And if you'll look at your notes or what has been provided in that book and at the conclusion of your notes of her interview, [redacted] tells you that it appeared to her that [redacted]'s story just kept growing.
A That's correct.
Q All right. If you would, please read that into the record, Doctor.
A So, "[redacted], who was present at a subsequent interview of the patient by Bernie Boulanger, MD, Chief Medical Officer, Cliff Iler, legal counsel, Margaret Pisacano, risk management, and the patient's mother. During this interview done by Dr. Boulanger, [redacted] made no remarks or remembers that Mom made little comment. [redacted] indicates that the patient gave his own account of the events related to the procedure. [redacted] does indicate that the detail of the events seemed to, quote, grow between the versions told by Mom to her the previous day and what the patient indicated during this interview."
Q All right. So let's drop back to Mom. You didn't have occasion to interview Mom?

A We -- we did not -- we did not interview Mom.
Q All right. But Mom's complaints in your report are registered, are they not?
A They are.
Q And they're registered in terms of bullet points, are they not?
A They are in the same format as the documentation from the customer relations specialist.
Q All right. And if you will, if you'll look at Mom's complaints, I think Mom said that her son was called a "fucking quad" in the endoscopy suite, correct?
A Correct.
Q But that's Mom relaying that message, and Mom wasn't in the endoscopy suite, was she?
A To my knowledge, she was not in the endoscopy suite.
Q And then Mom has other complaints that she wasn't present and are not even consistent with her son's; isn't that true?
A I'm not sure.
Q Well, doesn't Mom say that he was called a "fucking quad" near his room or something a couple of days before? If I'm mistaken, just

tell me I'm mistaken.
A In the copy of the Facebook document, it says, "Nor does it give you the right, while you're making a round three days ago to call him," and I quote, a bunch of F's with some alphabet characters, "quad because he can't" -- it says "life his hands." I assume it meant "lift his hands."
Q And if you will, didn't the mother also complain that residents or nurses had to lay across his body to hold him down in her complaints? I think -- yeah, look on the other page.
A The complaint says, "He said someone got on top of him to hold him down while the incision was made."
Q All right. Based on your experience, as well as my experience with [redacted] injuries, nobody had to get on top of him and hold them down, would they?
A They could.
Q All right. But in all probability, he's not moving; isn't that true?
A He's moving.
Q Is he?

A He's moving.
Q Okay.
A He's moving.
Q What parts of his body is he moving?
A He's rotating his shoulders and his trunk, and therefore, because of kinetic chain, his legs and trunk will go with him.
Q Wouldn't you just have to move his shoulder back over?
A My -- so one issue during our investigation that was called into question was, did Dr. Kearney forcefully restrain or physically harm the patient during the procedure. And so we made it a point during our open-ended questions of each interviewee to say, was the patient moving and did you have to restrain him? You'll see that theme walking through each interview.
Q I do see it. That's why I'm raising the question.
A Right. So based on his neurological level, he was not restrained prior to entering the room because I assume -- they assumed as [redacted] he would not need to be restrained, whereas many other patients are restrained before

entering the room for the procedure in an effort to protect them, not in any other effort.

Q But if he was not restrained during the procedure, what would that tell you?

A That they felt like he was not going to move, but clearly in multiple interviews it indicates that people were having to hold his hands down, hold his arms down, hold his shoulders down because he was attempting to remove the scope.

(SOTTO VOCE DISCUSSION.)

MR. PAFUNDA: We're arguing.

THE WITNESS: That's fine.

BY MR. PAFUNDA:

Q In any event, so those interviews were with the residents and nurses that were present that you interviewed?

A Yes.

Q All right. So based on that information, then, did you know at that time [redacted] was [redacted]?

A I did not know that information until Dr. Kearney shared that information during his interview.

Q So if there was a biting incident in the endoscopy suite, that could present a danger, could it not, to the resident or residents?

A Biting is bad, period, yes.

Q I know it's bad, but with [redacted] you need to stay away from it?

A Yeah, getting bitten is not a good thing.

Q Okay. And I take it that it's been since -- you haven't performed any clinics since 2007?

A I am still clinically active 50 percent, just not inpatient side.

MR. PAFUNDA: If you'll give me just a minute, I've only got, I think, one or two other questions and I may be finished.

(OFF THE RECORD.)

BY MR. PAFUNDA:

Q Dr. McDowell, do you do [redacted]?

A No.

Q All right. Finally, because I told the panel, did you put Dr. Kearney down as a job reference?

A In my 22 years here at the university, I am not sure.

Q All right. Well, the reason I asked you, if

you did put him down as a reference, that would be to underscore the fact that in your opinion he's professional? He's highly regarded, so you put somebody like that down for a reference?

A I would select him as a reference as someone that would honestly assess my skill set and provide that information.

Q I'm going to show you a document, all right, and I want you to be blunt with me. All right? Did you know that Mr. Iler called me and said after your investigation that you and Dr. Kearney were talking? Did you know that?

A No.

Q Okay. Because I didn't call you up and tell you that, did I? Are you ready? I'm going to show you this document.

A Yes.

Q Did you put him down as a reference?

A No, I did not. This was performed -- so Cardinal Hill Hospital was recently bought by HealthSouth.

Q Uh-huh (affirmative).

A We had to redo all of our credentials. I

signed the document, and then the staff decided who to send them to.

Q But that is your signature?

A That is my signature.

MR. PAFUNDA: Professor Lawson, I would like to make that an exhibit. I'd mark it, and I can go back and make copies of it. I want to show it to counsel. Do you have -- I'm going to show it to you.

DR. HAMILTON: Is this the recredentialing of Cardinal Hill that was required because HealthSouth bought the place?

THE WITNESS: Yes.

DR. HAMILTON: So this was basically a paperwork effort to continue to practice there?

THE WITNESS: Yes.

BY MR. PAFUNDA:

Q But whoever put down Dr. Kearney's name, all right -- let's walk through it. You just said it was staff, but whoever did it, it was not you because you didn't handle that particular matter for the credentialing; is

that correct?
A That's correct.
Q So if someone put his name down to make it look like you two were communicating, you would have no knowledge of that; is that correct?
A That is correct.
MR. SALSBUREY: Thank you, unless this is my copy.
PROFESSOR LAWSON: Let me have it. You want to introduce it as an exhibit?
MR. PAFUNDA: Yeah.
PROFESSOR LAWSON: All right. I'm going to call these exhibits that you're introducing separate from these others --
MR. PAFUNDA: They are.
PROFESSOR LAWSON: -- a special exhibit.
MR. PAFUNDA: They are.
(SPECIAL EXHIBIT 1 MARKED FOR THE PURPOSES OF IDENTIFICATION, AND THE SAME IS ATTACHED HERETO.)
MR. PAFUNDA: I don't have anything further.
PROFESSOR LAWSON: Go ahead.

EXAMINATION

BY MR. SALSBUREY:
Q Briefly, Dr. McDowell, you had been asked before on cross-examination and you had testified about how you had hoped perhaps a single incident wouldn't be something that would be career ending. But with Dr. Kearney, though, you had investigated multiple professional incidents, correct?
A Yes.
Q And Dr. Zwischenberger's -- I believe it was in the draft document we talked about. The fact that Dr. Kearney was not, in fact, removed from the position at issue, that doesn't mean it wasn't considered, correct?
A I would assume it was considered because it was put in writing.
Q Okay. With the December 2012 reprimand that we've been talking about, two different versions in the amendments to your report, isn't it true, in fact, that the version Dr. Kearney signed did, in fact, note that there were no witnesses to the [redacted] incident?
A That is correct.
Q On page 8 of your report, you interviewed

Dr. Cox, and is it not true that you found out from her that, in fact, Ralph Strong was not in the room the entire time of [redacted]'s procedure?
A That's correct.
Q You have been asked about whether you knew Dr. Karpf had threatened to fire Dr. Kearney. Do you know for a fact whether Dr. Karpf ever threatened Dr. Kearney?
A I do not, no.
Q In fact, Dr. Karpf never told you how your investigation had to be conducted; is that correct?
A That's correct.
Q You had been asked about -- quite a bit about issues with [redacted]'s mother and her complaints and inconsistencies. You've been asked a lot about whether and how documents you reviewed were selected. You've been asked about how [redacted] talked about how the mother's complaints and stories and [redacted]'s seemed to be growing. But the fact remains that you and Dr. Bezold did interview Dr. Kearney directly, correct?
A Correct.

Q And, again, he admitted to you that he had called [redacted] a "dumb ass," correct?
A Correct.
Q That he could be harsh with residents?
A Correct.
Q And that he could almost guarantee you he used profanity?
A Correct.
Q And that he likely yelled?
A Correct.
MR. SALSBUREY: All right. That's all the questions I have.
PROFESSOR LAWSON: Anything else, Mr. Pafunda? I think this is probably as good a time -- does the board have any questions of this witness?

EXAMINATION

BY DR. HAMILTON:
Q Just one quick thing. You said that Dr. Kearney was the first surgeon you attended as a medical student?
A As a resident.
Q As a resident. What do you recall from that time?

A I recall rounding in the ICU with him because we rounded as a team. I remember rounding in the morning. I remember rounding in the afternoon. I remember the excitement of being in the trauma bay and having traumas come in. I remember being well-supported by the faculty and the residents because it was my first rotation, and I'm not a student from UK, so I remember it being a valuable asset to my education as a rehab physician.

Q And his behavior at the time?

A I -- I do not recall any behavioral episodes that stick out positively or negative during that time.

DR. HAMILTON: Thanks.

PROFESSOR LAWSON: Any other questions? Let's take a 30-minute break for lunch, and we'll come back in here. We've got a lot to do, so it's going to be very difficult if we don't proceed with dispatch. Hope you will be focused more narrowly on the issues; otherwise, we'll have a hard time getting through the proceeding. So back in here in 30 minutes.

MR. SALSBUREY: Yes, sir. Thank you, Dr. McDowell.

(BREAK TAKEN.)

PROFESSOR LAWSON: Doctor, all the witnesses testifying here today are asked to testify accurately and truthfully. On behalf of the hearing panel, I ask you to commit to do that.

THE WITNESS: I do.

BERNARD BOULANGER, M.D.,
testified as follows:

EXAMINATION

BY MR. BEAUMAN:

Q Dr. Boulanger, please tell us your name for the court reporter's benefit.

PROFESSOR LAWSON: You've got to speak a little louder.

MR. BEAUMAN: Yes, I will be glad to.

A My name is Dr. Bernard Boulanger.

BY MR. BEAUMAN:

Q How long have you been at the University of Kentucky?

A Since 1998.

Q Your current position is what?

A I'm the chief medical officer for UK HealthCare.

Q As the chief medical officer, do part of your duties include any involvement with disciplinary issues relating to conduct of UK physicians?

A Yes.

Q How so?

A Chief medical officer has oversight of medical staff, amongst its other responsibilities, including provision of patient care.

Q When did you first become involved in any disciplinary issues related to Dr. Kearney?

A I would say that began after I became chief medical officer in June 2012. Prior to that time I was associate chief medical officer and medical director of operating rooms. I was aware that there were things happening before 2012, but I wasn't a part of that. I wasn't intimate in those discussions at all. So my involvement really starts June 2012 when I became chief medical officer.

Q At the table there before you is a binder of exhibits. I'm going to ask you about the

first occasion you had to become involved with complaints made about Dr. Kearney's behavior, and specifically there at Tab 1 deals with reprimand. The panel has already heard portions of this, but they can hear it from you since you were involved in it. If you can, explain these incidents that arose in 2012, please.

A Yeah. We became aware of a cluster of incidents related to Dr. Kearney I believe in May, August, September of 2012. They involved the OR staff, and there's three women here: [redacted], [redacted], and [redacted]. These incidents were investigated, and the written reprimand signed by Dr. Kearney on January 9, 2013, arose from these incidents. The [redacted] incident involved an alleged smacking on her shoulder, to which she replied that she was pregnant and had an exchange of dialogue with Dr. Kearney. The second incident, [redacted] --

Q If we could, before we get to the second, let's wrap up the first one there. I believe Dr. Kearney denied touching [redacted] on

the shoulder.
A That's right.
Q But he did acknowledge that the interaction occurred, that he made the comments that were attributed to him by [redacted], correct?
A That's correct.
Q Okay. Let's move on to the second -- for the middle one involving [redacted], and look at the August 2012.
A Yeah. [redacted]'s one event occurred related to some movement of staff within the operating room while Dr. Kearney was operating. After the procedure was finished, and this is a fairly memorable quote, he said to her, "You should have a colostomy bag around your head; you have shit for brains." Apparently this was made in front of other UK employees as well.
Q I believe there was some dispute in looking into this about whether it took eight minutes or 15 minutes or whatever the time frame may have been --
A Uh-huh (affirmative).
Q -- that [redacted] was to secure a replacement nurse. Regardless of that, did

Dr. Kearney admit that he made the colostomy bag comment to [redacted]?
A Yes.
Q All right. And the third incident with [redacted] in May of 2012.
A Correct. [redacted] was a scrub nurse, and she had scrubbed in on a patient, a case of Dr. Kearney's, and was greeted with, "Hey, bitch." She didn't appreciate that form of greeting and, you know, recounted, you know, at that time that she had been treated like this in the past by Dr. Kearney.
Q Did she also make a statement whether she had actually approached Dr. Kearney about his --
A Yes.
Q -- statement to her?
A Yes.
Q And that she had told him that she didn't want to be talked to with that kind of language?
A Yes.
Q Did Dr. Kearney deny making that comment to [redacted]?
A No.
Q And did he advise at that time whether he

wanted her scrubbing in on his cases?
A He did not.
Q And did he explain that she always cried whenever she was around him or if he yelled or raised his voice?
A Yes.
Q So what was the result of looking into these three separate incidents over the course of 2012?
A Well, there was -- this, I think, was another example to those involved of recalcitrant, unprofessional behavior on the part of Dr. Kearney, and a written reprimand was put together, which he voluntarily signed, and then agreed to the action plan that he would refrain from future unprofessional conduct. This included either physical conduct or profane comments is the language that is used in the agreement. Also, that if he violated any of the terms of the agreement, that he would be subject to corrective action.
Q If I can direct your attention to the bottom of what's page 2 in the binder, the last paragraph. It states what the purpose of the reprimand and action plan is. If you could

read us what's there and explain in your own words what you hoped to obtain from signing this agreement with Dr. Kearney.
A Yeah, that's a great question. 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. We had hoped that he would end his career in a, you know, peaceful, you know, classy manner. That was the sincere hope on my part and on the others involved in fashioning this agreement. Also, 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 himself at risk and he's putting the university at risk. So that was also discussed with him.
Q And, in fact, I think the plan notes, numerical paragraph five on the last page, which was page 3, if you violate any terms of this action plan you'll be subject to corrective action?

A Yes.
Q And this document was to be placed in Dr. Kearney's personnel file, correct?
A Yes.
Q And I believe, as paragraph two states, his upcoming performance evaluation for the 2012 year would reflect that these incidents had occurred and that he would face discipline?
A Yes.
Q Were those, in fact, included in his 2012 performance evaluation?
A Yeah. I wasn't a part of his performance evaluation. I have seen it, but I wasn't a part in, you know, constructing it or in having him sign it or not sign it.
Q And are you aware that he refused to sign -- that Dr. Kearney refused to sign his 2012 performance evaluation?
A Yes.
Q All right. Did this last-chance agreement work?
A Well, we were hoping it would work; we really were, but it didn't.
Q When did you become aware that Dr. Kearney was not living up his agreement that he had

entered into with you in January of 2013?
A On the late afternoon of September 4th of 2014, I received an e-mail that was directed to me. There were several people on the cc line, but it was directed at me, and it came from one of our customer relations specialists.
Q And I believe this e-mail, and I would like to have it in front of you, is page 76 in the exhibit list. If you could turn to that, and let me ask, is that the e-mail you're referring to?
A Yes.
Q And the panel may know, but just real briefly explain what these complaints are and how they come to you.
A Yeah. So we have a responsibility to respond to patient complaints, as you know. It was both Joint Commission and CMS regulations around responding to patient complaints. So there's a process set up whereby if a family or patient or anyone, actually, lodges a complaint, that there's a process by which that's distributed to the right people by the Office of Service Excellence, now called the

Office of Patient Experience.
Q So you're, I'm sure, at a meeting or wherever you are that afternoon when this e-mail comes in. It looks to be 3:35. What was your initial impression and reaction to reading this e-mail?
A I will say I was a little shocked by the e-mail, by the language and the allegations, honestly. And it became, you know, clear that we had to do some things here, and one of those was because of the message in the e-mail and also because the patient had had some contact with Margaret Pisacano, one of our risk attorneys. I think an attorney she knew, knew Margaret, asked the mother of [redacted] to contact Margaret. And she had shared with Margaret that they didn't want Dr. Kearney involved in the care of [redacted] anymore. The family and the patient didn't want him in the room. So I received that information from Margaret Pisacano, as well as I think that's included in the complaint: "I don't want this doctor touching my son or even in his room anymore." So in these circumstances, there's a few

things here, but there's alleged patient abuse here, you know, verbal patient abuse.
Q So after assessing the e-mail, what did you do that day in response?
A I made contact with Dr. Kearney early that evening, and we had a very mature conversation about the fact that we needed to get him away from this patient and the family, that this seemed like quite a volatile situation, and he agreed to do that. He was very cooperative with that. I also -- it was my responsibility as chief medical officer to make sure that patient was cared for. And I talked to Dr. Phillip Chang, as well, who sort of manages the schedule for trauma surgery, and explained that, you know, there was a patient interaction with Dr. Kearney and we needed to get him away from the patient. And so he arranged for Dr. Tucker, I believe, to take over the care of the patient. So the patient, you know, we had moved Dr. Kearney away from the patient but secured the care of the patient required.
Q In your phone call with Dr. Kearney that afternoon, did you explain to him who was

involved in the complaint, that this was Patient [redacted]?
A Yeah. I didn't make any notes of that phone call, but I remember telling him it was [redacted] and it was a complaint and they were unhappy with him and they didn't want him involved any more in his care.
Q Did you explain to Dr. Kearney the language that he was accused of having used?
A No, I don't recall telling him that.
Q And Dr. Kearney's reaction to having learned that the [redacted] had made a complaint was what? Was he surprised? Did he deny it?
A No. He didn't really ask me about it on the phone, but he was cooperative with the request to, you know, allow someone else to take over care of [redacted].
Q Okay. So after speaking with Dr. Chang and Kearney, what did you do the next day in response to this?
A Yeah. The patient had requested -- or I'm sorry, the patient's mother had requested that Margaret Pisacano visit them the next morning. That would have been a Friday morning. And we made the decision that we

needed to go talk to this patient. We needed to find out what had happened. These are serious allegations. We needed to at least hear it from the patient directly if we could. So I went to the patient's room with Cliff Iler and with Margaret Pisacano. And we brought Cliff Iler because Cliff Iler was very aware of, you know, past -- you know, the past dealings with Dr. Kearney, and he was involved in the development of the written reprimand, and I wanted him to hear what the patient said as well.
Q Who conducted the interview?
A Me. I interviewed the patient myself in the patient's room. His mother was present. [redacted], the nurse manager, was present. Margaret Pisacano and Cliff Iler were present, but they didn't interview the patient.
Q So tell me what you learned from your interview with [redacted].
A It was a striking interview. And I walked into the room almost not believing this had occurred because it seemed quite striking, but I found him to be highly credible. He

had -- he had very good memory at least of the beginning of the [redacted], the procedure. I've done a lot of these, as Dr. Kearney has, and he remembered the details of the room. He remembered that a male was trying to make the small incision in the abdominal wall that you make to, you know, [redacted], and that that didn't go well, and he remembered a female being replaced with this male to do that part of the procedure. So he remembered a lot, a lot of detail.
Q What comments did he relate to you that he had heard or had been directed to him while in the suite?
A Yeah. So the first comment that he had that he had heard from Dr. Kearney, and I'm paraphrasing a little bit here, but, you know, there was difficulty [redacted]. Dr. Kearney, you know, told people in the room to "Pry his F'ing mouth open." So he said that to me indirectly. There was also a comment made, I think he might have -- well, he did. He asked for more sedation. It really sounded like to me, having done a lot of [redacted], that he was awake.

This was an awake patient, excellent memories, interacting with people in the room. He asked for more sedation, and he told me Dr. Kearney said to him something like, "We don't do that," or "It's not necessary, you F'ing idiot." Okay? And whenever he would say something like that to me, I would ask him, "He was talking to you, right? He was talking to you? He was looking you in the eye saying these things?" And he said, "Yes, absolutely, he was talking to me." He recalls that there was cursing at the other doctors in the room. The patient recalled that clearly. He also relayed, you know, comments that were not made at him, but to the patient it sounded like they were made to the person doing the procedure on the belly, where Dr. Kearney told him or whoever was doing it at that point to "F'ing cut him." Okay. So --
Q Was there any details about the struggle that was when the [redacted] and the risk of biting or anything about the bite block that he shared?
A He remembers having a, you know, bite block

in, and I'm sure it was going in and out of his mouth at the beginning of the procedure, so he recalls there being some action with a bite block.

Q All right. So you interview [redacted]. What do you do next at that point?

A Well, we -- you know, his mother was present and, you know, she made the complaint and, you know, so we linked the complaint to our interview so that she knew that we were aware of the incident and exploring it. After the interview was done, I can recall Cliff, Margaret, and I, we just thought it was a credible interview with [redacted], and it sort of -- it raised the concerns. The mother was making allegations, but after interviewing the patient, it raised our concerns that we really might have something here, I mean, there might be -- this very well might be an example of verbal abuse against a patient and the use of profanity towards the residents, students, or others in the endoscopy suite room.

Q So at that point did you believe that a further investigation was warranted beyond

just speaking to [redacted]?

A Yes.

Q So what did you direct to happen?

A Well, we -- you know, I asked Cliff Iler -- Cliff is, for those of you who aren't aware of Cliff Iler, he is excellent. Very objective, fair, you know, in evaluating situations. I asked Cliff, you know, to independently conduct an investigation, to speak to the people involved, and, you know, then to report back to me.

Q So while you started that investigation through Cliff, what did you do with Dr. Kearney?

A Yeah, because of our concerns that this -- we had significant concerns that this was an event that contained verbal abuse against a patient and, you know, also cursing at staff or students or others in the room. It became clear that we had to get Dr. Kearney out of this environment for his own protection. Again, this was a pretty volatile situation. The patient, the family, and the mother were quite angry. I know there was social media posting on this as well. So the decision was

made by me that we should ask Dr. Kearney to go on voluntary paid leave.

Q And I believe that that administrative leave is Tab 4 there in the binder in front of you.

A Yes, that's correct.

Q So the investigation is conducted, and what are you aware of having been done for that investigation for you?

A Cliff came back to me on September 11th. I believe that's the date. He had spoken to a nurse, a tech, a couple of surgical residents, medical students, and Dr. Kearney, and we had heard from [redacted] already during our interview.

Q And what's significant about some of the comments that were reported back to you?

A Well, what was significant is that the allegations of the abuse of profane language towards the medical students and the residents was substantiated and that there was substantiation for the verbal abuse of the patient as the patient had described to me in the interview.

Q And, in fact, specifically as it related to Dr. Peterson, who was the one operating the

endoscope?

A Yeah.

Q His version, what was significant about his recollection of the events that day?

A Yeah. His recollection, as he told to Cliff, he reported to me, it was highly significant to me. He was a surgical resident. He had used the exact same phrase that [redacted] used when I interviewed [redacted], and that is, you know, "We don't do that for this, you F'ing idiot."

Q And that corroboration by Dr. Peterson, did that in your eyes enhance [redacted]'s credibility about other items that occurred?

A You know, it did. But there were other witnesses to the scope who also substantiated the claim that Dr. Kearney had cursed at the patient.

Q Now, during this investigation of the [redacted] incident, did other allegations come to light? And specifically I want to ask you about [redacted].

A Yeah. [redacted] was -- I believe this was a letter that Cliff Iler received from [redacted], who was an OR nurse at Good Samaritan

Hospital, like at the end of October. It was later on. It was end of October, early November, in that time frame.

Q And if you will, in the exhibits in front of you, pages 83 through 86, other correspondence and looks like one letter and an e-mail chain that relate to that. But did you learn that [redacted] reported she was called an "F'ing retard," "dumb ass," or "F'ing moron" --

A Yes.

Q -- by Dr. Kearney?

A Yes.

Q Did she also report that she was told that that was his normal behavior?

A Yes.

Q All right. So, Dr. Boulanger, you've got this report to you based on other witness interviews, your own interview with [redacted], obviously your recollection of everything that happened in 2012/2013, and the knowledge of everything. What were your conclusions at that point?

A It -- it was clear that a suspension at that point was indicated, and that was a

recommendation from my office. There was -- at this point, you know, legal counsel from the university was involved with this. I don't recall if Dr. Kearney had an attorney at that point, exactly. I assume he did. I think he might have, but I'm not clear on that. And so a decision was made by the university not to suspend at that point, to delay suspension to try and negotiate, you know, with Dr. Kearney so that we didn't have to suspend him and activate the medical staff executive process and so on.

Q So the process is turned over to the lawyers, so to speak. We do what we do, and eventually it comes back to you, knowing that there was no way to amicably work something out. And at that point, then, what did you do?

A Yeah, well, I wasn't aware of the negotiations with Dr. Kearney. I would hear that they had gone slowly or we're not making progress or we're making progress or so on, but I wasn't involved in the discussion as to how they would play out at all. And we were hopeful they would, and there were certain

points in the negotiation where we thought, okay, this is going to work and we thought that would be better for him and others. So I was informed in January that the negotiations had ceased, and so we were left with a, you know, physician who had met indications for suspension, and it was delayed to try and negotiate an exit for him, and that hadn't worked. So he was suspended on January 26th.

Q At that point you turned it over to the Medical Staff Executive Committee for them to review your actions?

A Yeah, correct. And the medical staff bylaws are -- you know, have many main purposes, but one of those is to protect physicians, and that is to protect them from wanton suspension or action. So as in the bylaws on the January 26th letter, the Medical Staff Executive Committee and Dr. Zwischenberger, I think Dr. -- I'm sorry, Ann Smith, who's the chief administrative officer for the hospital, was informed of the suspension, and then that triggers the Medical Staff Executive Committee process, which this is

part of.

Q Is it your opinion, Dr. Boulanger, that Dr. Kearney should be allowed to remain at this institution in providing care to patients or in a supervisory role of medical students or not?

A No.

Q Why not?

A Because of, as I said previously, the 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 2013.

MR. BEAUMAN: Thank you for your time this afternoon.

PROFESSOR LAWSON: Mr. Pafunda.

EXAMINATION

BY MR. PAFUNDA:

Q Dr. Boulanger, Bernard Pafunda. Is the personnel file confidential?

A I -- it's not as protected as other, you know, files may be.

Q My question is, is it confidential?
A Is it confidential?
Q Yes.
A Yeah. I think that that -- you know, his personnel file lies within the Department of Surgery.
Q Dr. Kearney's personnel file, is it confidential?
A It is, you know, certainly held in confidence, yes.
Q Did you know that -- well, first of all, let me preface it. You had a meeting, did you not, with Dr. Kearney on September 5th, I believe?
A Yes, it was the morning of September the 5th.
Q And that was yourself and Cliff Iler and Dr. Kearney; is that correct?
A That's correct.
Q And at that point he was put on administrative suspension?
A He -- no, not suspension at all.
Q Leave?
A He was put on paid administrative leave, which he agreed to.
Q Was there a document that he executed where

it shows that he agreed to that?
A No. It was the document that is in one of the exhibits I think we looked at. I don't recall the number.
Q It's an e-mail, correct?
A No. It was a document we gave Dr. Kearney on the morning of September the 5th. He walked out of my office with it.
Q And did he sign off on the document?
A No, he didn't sign off on the document.
Q Is there any portion of that document where the parties thereto, yourself included, Mr. Iler, and Dr. Kearney agreed that it would be a voluntary leave?
A He was told it would be a voluntary leave, and he was very cooperative at that meeting.
Q No, I know, but the difference is he was told it was a voluntary leave. Isn't it true he was told to leave?
A We -- we asked him to leave.
Q All right. Thank you. Thank you very much. Now, a few days later, was Dr. Michael Karpf alerted to the fact that Dr. Kearney had been suspended?
A Dr. Karpf was informed that Dr. --

Q I'm not playing lawyer games.
A I understand.
Q My question was prefaced with, a few days later was Dr. Karpf informed that Dr. Kearney had been suspended?
MR. BEAUMAN: Objection to form. It's not suspended: Leave.
BY MR. PAFUNDA:
Q Leave.
A He was informed of that, correct.
Q Thank you very much. And at this time he was informed he was on vacation, was he not?
A I don't recall that.
Q Were you aware of the fact that Dr. Karpf told Greg Goodman that Dr. Kearney was suspended because he hit a nurse?
A No.
Q Do you know who Greg Goodman is?
A Yes.
Q All right. He's the one who endowed the chair that has Dr. Kearney's name; is that correct?
A I believe so.
Q Are there many endowed chairs through private donations?

A I don't know a number, but there are some, yes.
Q For present employees of the university?
A I'm sorry?
Q There are only a few, are there not, for present employees of the university, endowed chairs?
A That have their own names attached to endowed chairs?
Q Yes.
A I don't think that's common, but I don't know a number.
Q And you were acutely aware, were you not, that Greg Goodman endowed Dr. Kearney's chair?
A I believe so. I was at an event I remember where that was kind of unveiled years ago.
Q And it was endowed to the tune of two million dollars due to the fact that Dr. Kearney provided excellent patient care to Mr. Goodman; is that correct?
A I don't know the answer to that.
Q Returning to my earlier question, then, you don't know that Dr. Karpf had a conversation with Mr. Goodman shortly after Dr. Kearney

was suspended?
A I'm not aware of that.
Q Hadn't discussed it at all?
A I don't recall it.
Q All right. Well, who's your immediate supervisor?
A Dr. Mike Karpf.
Q How did you become chief medical officer?
A There was a chief medical officer who at that time left, you know, for a big opportunity in Memphis named Dr. Paul Depriest.
Q When you say he left, that was Dr. Paul Depriest; is that correct?
A That's correct.
Q And you stepped into the position how?
A There were interviews, and Dr. Karpf appointed me as chief medical officer.
Q And as you've just related, you've been in that position now, what, two years?
A June 2012, so almost three years.
Q With respect to the 2013 written reprimand, there were two documents, were there not, that were placed in Dr. Kearney's file with regard to that 2013 reprimand?
A Yeah, I've seen two different documents.

Q You can look through the exhibits. Go ahead.
A Which exhibit would that be?
MR. PAFUNDA: That's their book.
MR. BEAUMAN: Look at pages -- bear with me -- 73. The unsigned one is 70, and the revised signed one starts at 73.
THE WITNESS: Yeah, right. I had seen an unsigned and a signed version of that document.
BY MR. PAFUNDA:
Q All right. The unsigned, as was just announced, is Exhibit 70.
MR. BEAUMAN: Page 70.
BY MR. PAFUNDA:
Q Page 70, excuse me.
A Okay. I see it, yeah.
Q All right. Why was an unsigned document placed in his personnel file?
A I don't know.
Q Have you removed at any time or placed any documents or caused to be placed any documents in Dr. Kearney's personnel file?
A I don't recall.
Q If you will, the unsigned document, if you'll

read the last sentence in that document into the record, please.
A Is this on page 72? Is that where we're --
Q It's on the first page of that.
A It's the first page of the unsigned document?
Q Yes.
PROFESSOR LAWSON: Is it not on the second page?
MR. SALSBUREY: You're talking about the bottom of the first page.
MR. PAFUNDA: The bottom of the first page.
THE WITNESS: Bottom of the first page.
MR. PAFUNDA: Please.
PROFESSOR LAWSON: He's asking you the difference between this and this one here.
A "Based upon the information gathered regarding this incident, I find [redacted] credible and I believe that the smack on the shoulder did occur."
BY MR. PAFUNDA:
Q All right. Now, if you'll turn to the signed portion.
A Okay.

Q And read that same sentence into the record.
A "Based upon the information gathered regarding this incident, I find [redacted] credible and I believe that the smack on the shoulder did occur, even though no one else interviewed witnessed the smack."
Q All right. Now, my question to you is two-fold. Number one, the documents are materially different, are they not, with respect to that investigation?
A The unsigned document and the signed document are different.
Q All right. Now, it's got the pronoun "I." Who did the investigation? Who made the statement that they believe?
A Well, the document is signed by Zwischenberger and by Dr. Kearney.
Q All right. But Dr. Kearney didn't do the investigation; you know that, correct?
A That is correct, yeah.
Q Dr. Zwischenberger didn't do the investigation, did he?
A I don't know how much of the investigation he might have done.
Q But if you look at the preamble in the

beginning paragraphs to that document on the first page, does it reveal who was doing the investigation at that time?

A Well, the names Cliff Iler and Patty Bender are here in the document.

Q So would it be reasonable to conclude that Patty Bender and Cliff Iler were doing the investigation?

A I don't recall who did the investigation, whether Dr. Zwischenberger did any part of it.

Q Or whether Dr. Zwischenberger simply signed off on a document that Dr. Kearney executed in 2013?

A Is that a question, sir?

Q But the big question hanging out there is: Why is there a false document in Dr. Kearney's file? Isn't that true?

A I don't -- I don't know why that document is in his file.

Q And you would agree with me that it shouldn't be in his file; isn't that true?

A I'm not clear that it shouldn't be in his file.

Q Are you saying it's university policy or

regulation that you can place false documents in an individual's file?

A No, sir.

MR. BEAUMAN: I'm just objecting. I don't think there's any foundation laid that anything in here is false.

MR. PAFUNDA: All right. We'll go through it again.

BY MR. PAFUNDA:

Q There's a material difference, is there not, between the signed and the unsigned document?

MR. BEAUMAN: That's been asked and answered.

MR. PAFUNDA: One's false and one's not; isn't that true?

PROFESSOR LAWSON: Just a second. It could be erroneous.

MR. PAFUNDA: If it's erroneous, it's not true.

PROFESSOR LAWSON: You're saying -- all I'm saying is you need to clarify this right here.

MR. PAFUNDA: I'll clarify it even further.

PROFESSOR LAWSON: Okay.

MR. PAFUNDA: I'll move to another document.

BY MR. PAFUNDA:

Q As chief medical officer, did you play any role whatsoever in who was selected to investigate on behalf of the Medical Staff Executive Committee?

A No.

Q All right. Earlier -- you became aware later at some point that Dr. Susan McDowell was part of that investigative team, correct?

A I was at the Medical Staff Executive Committee, the first meeting. I'm a member. I have one vote on that committee, and I believe at that meeting it was decided that Susan McDowell and Lou Bezold would do the investigation.

Q All right. She's just finished testifying or telling the panel that she was provided with certain documents from Dr. Kearney's personnel file in the course of her investigation. Did you know about that?

A I was not a part of their investigation.

Q All right. So you didn't know about documents being provided to her?

A I was interviewed by them, but I was not a part of the investigation. I didn't know -- I wasn't aware of the documents they were given or not given.

Q Did you know that Cliff Iler had supplied certain documents from Dr. Kearney's file to the investigative team?

A I'm not aware of that.

Q If I may, Professor Lawson, rather than refer to the book --

A Sure.

Q -- those are the documents that Susan McDowell was provided -- Dr. McDowell. Excuse me. And she gave me a copy. And of those documents, you'll see one there that says "draft document."

A Okay. I see R and F, so I assume that's a draft stamp on it.

Q What is a draft document doing in Dr. Kearney's personnel file?

A Sir, I don't know.

Q It shouldn't be in there, should it?

A I don't know whether it should be in there or not. I was not involved in 2010 in this draft document.

Q I'm not asking you whether you were involved, but should Dr. Kearney's file be papered with documents that are draft documents?
A I don't know the answer to that.
Q Do you know that the governing regulations require that, if an unsolicited document is put in a personnel file, the person should be given an opportunity to respond?
A I'm not aware of the specific language around the personnel file.
Q Who -- where is the personnel file maintained?
A Where is it physically maintained?
Q Yes.
A I'm not even sure where it is maintained.
Q As medical director in 2010, were you aware of these matters?
A I was not aware in any detail. I knew there were discussions. I didn't participate in any substantial manner. I don't have any recall, really.
Q With respect to [redacted], where is he from?
A Where is he from?
Q Yes.

A I don't recall where he's from.
Q And you had just one occasion to speak with [redacted] directly?
A That's correct.
Q Did you learn who his lawyer was at the time or is?
A No, sir.
Q Not from Margaret Pisacano, no one mentioned it?
A She might have told me, but I don't recall.
Q But you knew at the time that he had a lawyer?
A I was aware that he had an attorney related to the accident and it was that attorney who had asked Margaret to get involved.
Q And when you conducted the interview with [redacted], did anybody take notes?
A I don't recall anyone taking notes. I didn't take notes.
Q Well, you had two lawyers present. Did they take notes?
A You know, I don't recall if they did or not. I'm not sure.
Q But you would agree with me, as you noted in response to questions from counsel, that that

interview was a significant interview with respect to Dr. Kearney's behavior, correct?
A It was a significant interview with respect to the allegations of verbal abuse.
Q Right. So you had both patient concerns and Dr. Kearney concerns, correct?
A We had staff concerns, medical student concerns, resident concerns as well.
Q And in that regard, with two lawyers present, were notes taken?
A Sir, I just don't recall. They might have been.
Q If notes were taken, who would maintain custody of those notes?
A I would presume the attorney would.
Q All right. Did [redacted] also complain that Dr. Kearney made the remark that he was a "fucking quad" while Dr. Kearney was in his room?
A He relayed that to me during the interview.
Q Uh-huh (affirmative).
A It had apparently occurred, I think, a couple of days before --
Q Correct.
A -- the event in the endoscopy suite. He

definitely heard it. [redacted] remembers hearing it.
Q So the answer to my question is, yes, he stated it happened in his room, correct?
A He stated that it happened and he heard it. I don't recall him saying that it happened in his room.
Q And did you ascertain whether a resident was present with Dr. Kearney when this statement was made?
A I do not -- I don't think that was specifically investigated, and I remember [redacted] saying there was somebody else present and he thought it was a resident, something like that.
Q Well, let me ask it this way. I take it from your responses that after you interviewed [redacted], number one, you jumped to the conclusion that he was credible in your opinion?
A No, I don't think we jumped to the conclusion at all.
Q Well, you made the conclusion he was credible?
A That is correct.

Q Number two, you then met with Dr. Kearney along with Cliff Iler?
A Correct.
Q Within a day?
A Yes. There was some urgency. Once we had heard that from the patient, would we want a caregiver who has allegations against them of verbal abuse against the patient in our hallways caring for other patients? We needed some time to sort it out, but we had significant concern that it actually occurred just based on the interview with [redacted].
Q And before you met with Dr. Kearney, did you impress that fact upon Mr. Iler, that in your opinion [redacted], in fact, was credible and you believed the incident had occurred?
A Okay. You're -- Mr. Iler and I discussed after the interview that we thought [redacted] was credible.
Q No, I understand.
A Right.
Q So after you met with Dr. Kearney and he goes on administrative leave, you then hand the entire investigation over to whom?
A I asked Cliff Iler to do an independent --

independent of me, independent of anyone else -- investigation of the incident.
Q So Mr. Iler would have determined, would he not, in his investigation who was present in the endoscopy suite when this was allegedly said, correct?
A He had a list of people that he interviewed, right.
Q All right. And, likewise, he would have had -- if there were residents present on rounds in [redacted]'s room, he would have had a list of those persons, also; isn't that true?
A I don't know if he had that list.
Q Is that list still maintained, if you know?
A I've never seen a list like that.
Q Well, you just said he had a list of names.
A Well, he had a list of names of people to interview. I've never seen that list.
Q And I take it, during the course of his investigation, he would have also made notes, correct?
A I think you'd have to ask him that.
Q So you weren't privy with the results of his investigation?

A He reported back to me the results of his investigation.
Q He reported back what, Doctor?
A He reported back the results of the interview with the endoscopy tech, with the nurse in the room, with two residents, a medical student, and Dr. Kearney.
Q And you concluded as a result of that report?
A That the allegations made by [redacted]'s mother and [redacted] of verbal abuse of the patient and the use of profanity towards others in the room, including housestaff/ medical student, were substantiated.
Q Now, you were aware, were you not, that over the course of his career at the university Dr. Kearney does not have a single patient complaint lodged against him other than this [redacted]?
A I'm not aware either way.
Q But from the time you came on board in your position as chief medical officer and the reprimand was signed January of 2013, there had been during that span of time no patient complaints against Dr. Kearney, had there been?

A I don't recall any others during my time as chief medical officer.
Q And as Mr. Iler was doing the investigation, so that you would be able to determine what discipline to hand out to Dr. Kearney, no one revealed to you, other than the [redacted] complaint, that in all his 27 years there had been a patient complaint; is that right?
A I wasn't made aware of any issue prior to my arrival as chief medical officer.
Q So to answer my question, then, the only patient complaint in those 27 years that you're aware of is the [redacted] complaint?
A Yes, that I'm aware of.
Q And if there were patient complaints to the level of the [redacted] complaint, they certainly would have been lodged or noted either in his performance evaluations or in his personnel file in another matter?
A During my time as chief medical officer, if there had been a patient complaint of an allegation of this severity, yes, I would have known about it.
Q All right. And in your time and based on your experience, if there had been patient

complaints in the past, they should have -- to this severity, they should have been reflected in Dr. Kearney's or any other physician's performance evaluation; isn't that true?

A Well, the performance evaluations are done within the College of Medicine. They're done by either the division chief or the chair of that faculty member.

Q And signed off by the dean?

A And so I -- you know, that's who does the evaluations. They might not have included something in there. I have no way of knowing.

Q But over 27 years, if there had been a pattern of patient complaints of this severity, they certainly would have been registered in his performance evaluations; would they have not?

A I don't think that's, you know, necessarily the case.

Q Or his personnel file?

A Again, I -- I don't think that's necessarily the case.

Q But necessarily the case is, and this is your

whole argument and you just told the panel, you don't want a rogue physician at the university, do you?

A We don't want a physician who verbally abuses patients and verbally abuses staff, medical students, and residents; that is correct.

Q So if you have a physician who has won -- or been granted 29 teaching awards over his 27 years here, that would certainly highlight the fact that that particular physician, in terms of teaching residents, is doing an excellent job?

A I don't recall what all the teaching awards were for, you know. Certainly Dr. Kearney has won teaching awards. I don't think anybody is disputing, you know, certain aspects of his work here. Part of being a physician is professionalism.

MR. PAFUNDA: Well, if I may approach.

PROFESSOR LAWSON: Yes.

MR. PAFUNDA: Thank you.

BY MR. PAFUNDA:

Q Dr. Boulanger?

A Yeah, I'm aware of Dr. Kearney's teaching awards. I really congratulate him for that.

He's put a lot of time and effort into the medical students. This isn't in dispute.

Q All right. So it's indisputable, uncontroverted that in terms of professionalism, this is one of the highest professionals at the university, Dr. Kearney?

A I think he's proven with his, as I said, his recalcitrant behavior, unprofessional behavior, and the incident of September the 3rd, that he was, you know, extremely unprofessional with a patient and with others in the room, with the interaction with [redacted] that came later, that he --

Q Well, just a second. You said [redacted] came later. When did [redacted] work at this university?

A The letter from [redacted] to Cliff was, I believe, the end of October.

Q No. My question is, when did [redacted] work at the university?

A Sir, I don't recall that.

Q All right. So you, as chief medical officer, would take away his teaching awards?

A Take away his teaching awards?

Q Yes.

A That -- you know, that's not the question here. This is a medical staff bylaw issue, and it relates to his privileges and his ability to practice as a physician at UK HealthCare. We -- his teaching awards are something different.

Q But they are not different in this regard. When he conducts teaching, he's teaching residents in terms of on rounds and in the operating room; isn't that true?

A Certainly.

Q And in the whole panorama of the clinical setting; isn't that true?

A Yes.

Q So those awards underscore his professionalism in that arena?

A I think they underscore his teaching ability, which --

Q Well, it underscores his teaching ability as well as his communication and his relationship with his students?

A I think they're awards based on his teaching ability.

Q All right. Now, in terms of professionalism, over 27 years Dr. Kearney has had over

500,000 patient and staff interactions. Would you agree with that?
A I'm not sure where that number comes from, but he's had many.
Q Would you agree that many includes hundreds of thousands?
A I don't know if it's hundreds of thousands.
Q But if you're making rounds on -- when you were in the Department of Surgery and you were on clinic, did you make rounds?
A Yes.
Q And when you made rounds, you would also interact with staff?
A Uh-huh (affirmative).
Q And it would include the whole scope, correct, nurses, staff, residents?
A Yes.
Q All right. So over those 27 years, what it boiled down to is maybe six complaints about Dr. Kearney's behavior?
A I don't know the number. I'm very aware of the ones that occurred while I was chief medical officer.
Q The ones that occurred while you were chief medical officer are where he signed off in

2013, and then the [redacted] complaint, and then the [redacted] complaint?
A That's correct.
Q So if the [redacted] complaint is bogus, what remedy?
A Well, there's nothing to make us think it's bogus.
Q All right. If the [redacted] complaint was registered in order for her to be able to leverage a monetary advantage with the university?
A I had no contact with [redacted]. I believe Patty Bender may have talked with her, interacted with her, so I have no knowledge of [redacted]'s circumstances.
Q If you had a faculty member who actively abuses residents, should that person have his or her clinical privileges suspended?
A Physically abuses residents?
Q Yes. Throws them up against the wall, grabs them by the throat and throws them up against the wall.
A That would have to be looked at on a case-by-case basis, absolutely.
Q You would agree with me, would you not, that

that's pretty darn extreme?
A If that had occurred?
Q Yes. If that, in fact, occurred, and I'll even throw this at you, even if it occurred several years ago, should it be brought out in the light of day and that physician who assaulted those residents have his or her clinical privileges removed -- or suspended? Excuse me.
A Well, there's a lot of theoreticals and ifs there.
Q Yeah, but if it's shown to be a fact?
A If it was shown to be a fact at the time it occurred, was investigated and so on, then it's a case-by-case decision as to how to handle that.
Q But you, as chief medical officer, how would you handle it?
A Well, as you can see by the amount of documents, the amount of testimony you've heard today, there is a lot involved in investigating an incident like that.
Q Didn't you and Dr. Kearney once have a discussion about professionalism with respect to physical abuse of residents?

A You know, we worked together for years and years.
Q That's not my question.
A I don't recall any discussion.
Q Didn't Dr. Kearney advise you not to physically abuse residents?
A Sir, I don't recall that.
Q You would agree with me, though, that physical abuse, physical abuse of residents is unprofessional?
A I would think it was if it was substantiated.

MR. PAFUNDA: That's all.

MR. BEAUMAN: Just real briefly, Dr. Boulanger.

EXAMINATION

BY MR. BEAUMAN:

Q Medical students or residents aren't going to be as critical of behavior or conduct of an attending physician as the attending's peers would be?
A That's a hard question to answer in general. You know, obviously trainees have a lot at stake if they're going to make claims against their supervisors, but that's a very hard -- you know, it's a hard question to answer.

MR. BEAUMAN: Thank you. That's all.
MR. PAFUNDA: I have nothing further. Thank you, Dr. Boulanger.
PROFESSOR LAWSON: Call your next witness.
MR. BEAUMAN: Okay. We'll check on Ms. Swartz.
MR. SALSBUREY: We're going to call Colleen Swartz next, sir.
PROFESSOR LAWSON: Well, get her.
(BREAK TAKEN.)
PROFESSOR LAWSON: Ms. Swartz, all the witnesses who are testifying before the hearing panel today are asked to affirm that they will testify accurately and truthfully. On behalf of the hearing panel, I ask if you will commit to do that in giving your testimony.
THE WITNESS: Sure, absolutely.
PROFESSOR LAWSON: Proceed.
MR. SALSBUREY: Thank you.

COLLEEN SWARTZ
testified as follows:

EXAMINATION

BY MR. SALSBUREY:

Q Ms. Swartz, for our court reporter's benefit, can you state your name for the record.
A Colleen Swartz.
Q And you are employed at the university, correct?
A Yes.
Q And how long have you been employed with the University of Kentucky?
A This time 10 years and 20 years before that. Had a little almost four-year break in service.
Q Okay. What are your current positions or roles at the university?
A I'm the chief nurse executive, so in that role I'm responsible for nursing practice no matter where it occurs across the system of health care.
Q Is it fair to say there are other places you would rather be today?
A Yes, that's fair.
Q That's fine. But you are familiar with Dr. Paul Kearney, correct?
A Yes.
Q Tell the panel how you know Dr. Kearney.

A We worked together starting in probably his arrival as a trauma faculty member, and then Dawn Barker was the trauma medical director at the time running the trauma program. And then when Dr. Barker left, Dr. Kearney assumed that role. We ran the trauma program together for that next 10 or 12 years.
Q Okay. So are you familiar with how Dr. Kearney interacts with staff just in general?
A Yes.
Q Okay. Have you ever known Dr. Kearney to become visibly upset with staff?
A Yes.
Q Okay. How does Dr. Kearney handle himself when he's upset with staff?
A Directive.
Q Can you explain a little more what you mean by that?
A It's matter-of-fact normally, but very open and honest and direct.
Q Have you ever known him to use profanity in dealing with staff?
A Yes.
Q Have you ever known him to call staff names

when dealing with staff? Let me give you an example. Have you ever known him to tell staff they are "fucking stupid"?
A I don't think I've heard him say that directly to staff. I've heard that he has said that to staff. I don't know that I've actually heard him say that.
Q Is it fair to say that Dr. Kearney has embarrassed staff that he's upset with before?
A Yes.
Q Is it fair to say that he's done it intentionally?
A Yes.
Q Okay. Is it fair to say that Dr. Kearney, in fact, works to identify and address something that he knows would embarrass a person he's upset with?
A Sometimes.
Q Okay. If a nurse knows or is fearful of being embarrassed or humiliated by their attending physician, can that have an impact on patient care?
A Yes.
Q How so?

A I think it can become a distraction because typically that creates 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.

MR. SALSBUREY: That's all the questions I have, Professor.

PROFESSOR LAWSON: Mr. Pafunda, do you want to cross this witness?

MR. PAFUNDA: Yes, please.

EXAMINATION

BY MR. PAFUNDA:

Q Ms. Swartz.

A Hi.

Q Has anything Dr. Kearney has done adversely affected patient care?

A I don't -- I can't say that for a fact.

Q But to your knowledge it's never happened, correct?

A That's correct.

Q [redacted]?

A Yes.

Q [redacted]?

A Yes.

Q [redacted]?

A Well, yeah, it turned out to be one.

Q But at the time you didn't know, and Dr. Kearney pointed you in the right direction, for lack of a better expression?

A Yes.

DR. KEARNEY: Within 30 seconds.

MR. PAFUNDA: Well, turned the light bulb on.

DR. KEARNEY: Sorry, I just had to mention it.

BY MR. PAFUNDA:

Q Can nurses' attitudes adversely affect patient care?

A Sure.

Q Are there nurses that bring in the wrong attitude?

A Yes.

Q Are there nurses that will make up complaints in order to strengthen their position?

A I would say probably.

Q And aren't there physicians all throughout UK HealthCare, not all of them, but aren't there many who use profane language?

A There are many.

Q All right. And aren't there many nurses who do likewise?

A Yes.

Q And are there patients who manufacture complaints?

A Yes.

MR. PAFUNDA: Thank you.

MR. SALSBUREY: No, sir.

PROFESSOR LAWSON: Thank you.

THE WITNESS: Is that it?

PROFESSOR LAWSON: Your next witness.

MR. SALSBUREY: I'll get her.

MR. BEAUMAN: Patty Bender.

MR. SALSBUREY: Our next witness and final witness is Patty Bender.

MR. PAFUNDA: Professor Lawson, we're going to need a bit of a break.

PROFESSOR LAWSON: Well, we are going to need to proceed.

MR. PAFUNDA: We may need to proceed, but they're in clinic, and so we have to work with them too. And we've done that ahead of time on the 3'o clock schedule.

MR. SALSBUREY: I can ask Patty what her

favorite color is if that would help.

MR. PAFUNDA: No, no.

PROFESSOR LAWSON: Well, maybe you can ask Mr. Iler to see if some of them could get here earlier.

MR. PAFUNDA: No, no. They're done.

PROFESSOR LAWSON: I'm not talking about you; I'm talking about the witnesses. He has agreed to help get the witnesses here.

MR. PAFUNDA: Well, my client's out there doing it right now.

MR. SALSBUREY: Patty, you can come sit by Professor Lawson.

PROFESSOR LAWSON: Ms. Bender, all the witnesses who are testifying today before the hearing panel are asked to affirm that they will testify accurately and truthfully. On behalf of the hearing panel, let me ask you if you will commit to do that in giving your testimony.

THE WITNESS: I certainly will.

MR. SALSBUREY: Okay.

PATTY BENDER

testified as follows:

EXAMINATION

BY MR. SALSBUREY:

Q Ms. Bender, for the court reporter, can you please state your name for the record?

A Patty Bender.

Q And you are employed with the University of Kentucky, correct?

A I am.

Q And for how long have you been employed with UK?

A 27 years now.

Q Okay. What is your current role at UK?

A I'm the assistant vice president for equal opportunity.

Q How long have you held that role?

A Since 2003.

Q And can you briefly describe for the panel what the responsibilities of your role are?

A Well, I have several responsibilities, but I investigate complaints of discrimination and harassment from both students, faculty, staff --

Q Okay.

A -- others on campus.

Q Okay. And are you familiar with Dr. Paul Kearney?

A I am.

Q And how are you familiar with Dr. Kearney?

A I have interacted with Dr. Kearney a few times over the years.

Q Okay. Can you describe the context of that?

A Well, I had a -- interacted with Dr. Kearney when I got a complaint from some students about some comments in class.

Q Okay.

A Before that it was language in the OR, and the most recent was -- I didn't interact with Dr. Kearney on the most recent.

Q Okay. Can you briefly tell the panel about the student complaint that led to interaction with Dr. Kearney?

A The student complaints were about some comments made in the classroom. One was a complaint of national origin, discrimination.

MR. PAFUNDA: Wait a second. That's not part of these charges.

THE WITNESS: Okay.

MR. SALSBUREY: Say that again.

MR. PAFUNDA: That's not part of the charges by the Medical Staff Executive Committee.

PROFESSOR LAWSON: Well, there's a document in the file to that effect, so I'm going to overrule your objection.

BY MR. SALSBUREY:

Q When were these student complaints? Do you recall?

A I don't remember.

Q Well, then, let's talk about the OR comment that you then -- complaint that you were talking about, language in the OR.

A The complaints that we got were -- was from a nurse, a person that we had hired, and she left and she said she left because of a hostile work environment, and we contacted her to try to get some information about that. And one of the complaints that she had was about language from Dr. Kearney.

Q Okay. And this was, in fact, a nurse named [redacted]; is that correct?

A Yes.

Q When were you first made aware of the

complaints from [redacted]?

MR. SALSBUREY: Let me do this. There's a binder we're going through that Professor Lawson can make available to you.

THE WITNESS: I don't have that in front of me.

MR. SALSBUREY: That's all right. I'm going to help you.

PROFESSOR LAWSON: What's the --

MR. SALSBUREY: We need to go to Tab 7 and page 84.

A This was back in November of 2014.

BY MR. SALSBUREY:

Q And how did this come to your attention?

A The complaint was actually sent to the legal office, and then it was sent to me to try to get in touch with her and see what the complaint was about.

Q And is the complaint you're referring to the one on page 83 there?

A Yes.

Q Okay. And so you received that complaint from the legal office, and then did you, in fact, make contact with [redacted] regarding

her complaint?
A I called her. I wanted to get her to see if she could come in and talk to me, but she wasn't available. I sent her the e-mail originally. I was having trouble getting in contact with her, the e-mail exchange. She had just started a new job and was not able to come in.
Q Okay. But pages 84 through 86 in front of you do represent your e-mail exchange with her, correct?
A Yes, correct.
Q And she did, in fact, inform you that Dr. Kearney had called her a "fucking retard," correct?
A Yes.
Q And a "fucking moron"? If you look at page 84 --
A Yeah.
MR. SALSBUREY: May I approach, sir?
PROFESSOR LAWSON: Yeah, go ahead.
BY MR. SALSBUREY:
Q Is that correct?
A Yes.
Q And in fact, it was her information to you

this was Dr. Kearney's normal behavior, correct?
A Yes.
Q But you said she had, in fact, left UK at this time, correct?
A Correct.
Q And were you able to investigate the matter any further?
A I referred this back to Cliff at that time, Cliff Iler, legal counsel.
Q And that, in fact, then ended your involvement in this particular matter, correct?
A Yes.
Q Okay. Ms. Bender, are you in your position familiar at all or ever had occasion to look at personnel files?
A I do.
Q And just with respect to medical staff, do you know where those are maintained?
A No.
Q Okay.
A I just call somebody.
Q Understood, not you personally. You don't know where they're kept?

A No.
Q Or how they are maintained?
A No.
MR. SALSBUREY: Okay. That's all my questions, Professor.
PROFESSOR LAWSON: Mr. Pafunda.
EXAMINATION
BY MR. PAFUNDA:
Q Ms. Bender, we have met before.
A We have.
Q You've always been gracious, and I've always been gracious. [redacted], when did she work at the university?
A I'm not sure. I don't have that information.
Q In preparing for today, and I take it when Mr. Iler passed this information on to you, that was some time ago, correct?
A It was in the fall of '14, right.
Q And in between the fall of '14 and now, this hearing, has anybody determined when [redacted] worked at the university?
A I don't have that with me. I mean, I could look it up, but I don't have that.
Q No, I know. It's not in any of the information that's in that package either, is

it? Correct?
A I don't know that.
Q What is in there is that [redacted] also complains about another physician, does she not?
A Yes.
Q And that physician's name is?
A Christensen.
Q All right. And her complaint about the two physicians, do you know what Dr. Christensen's specialty is, where he worked?
A He is not a university physician.
Q Was he at Good Sam?
A He had privileges at Good Sam.
Q All right. Do you know his specialty?
A I did. Wait a minute.
Q Orthopedics?
A I think he's -- well, he's a surgeon of some kind, yes.
Q All right. Gets him in the ballpark. Do you know when he worked at Good Sam, when he had privileges?
A No, I don't. I know he's not there now.
Q Neither is [redacted], right?

A No.
Q Just stated the obvious. And [redacted] leveraged this letter, which we've called a complaint, and she was forgiven a $2,500 payment she had to make to the university, correct?
A You would have to ask the legal office about that.
Q When you say the legal office, you're talking about Mr. Iler?
A Yes. I don't know what happened to that.
Q And the legal office over here at UK Health Center is separate and apart from the law office that you deal with over at the university, correct?
A Well, we have legal people in both places, but they're the same legal office.
Q All right.
A It's all the University of Kentucky Legal Office.
Q Okay. And when you say hostile work environment, that is actually a misnomer, is it not? Isolated remarks do not make a hostile work environment, do they?
A Each situation is different and has to be

investigated and considered in a different way.
Q All right. But I take it when you walk in, and if you've heard of an isolated or several isolated remarks, that you walk in with the approach that it is a hostile environment?
A Well, not necessarily. You know, it's like I talk about in training and, you know, one stupid remark doesn't make a discrimination complaint.
Q That's right. In fact, there actually has to be an act that follows a remark that makes it discriminatory, does there not?
MR. SALSBUREY: Let me object. That's calling for a legal conclusion.
MR. PAFUNDA: I am, and I'll withdraw it.
PROFESSOR LAWSON: Yeah, I know you are. You're pushing the limit. I understand you question her credibility; that's legitimate.
MR. PAFUNDA: No, I'm not. I'm actually trying to establish it.
PROFESSOR LAWSON: Well, argue your case at the end to the panel.

BY MR. PAFUNDA:
Q Ms. Bender, did you ever speak personally to [redacted]?
A On the telephone, yes, one time.
Q And in that telephone conversation, did you ask her when she had worked at the university and when she stopped working at the university?
A I don't remember.
MR. PAFUNDA: All right. Thank you. That's all I have. Good to see you again.
MR. SALSBUREY: No questions, sir.
PROFESSOR LAWSON: Thank you.
MR. SALSBUREY: Thank you, Ms. Bender. We'll reserve the right to call any witnesses we need for rebuttal.
PROFESSOR LAWSON: You have a right to rebuttal after Mr. Pafunda produces his evidence, but you're closing your case right now?
MR. SALSBUREY: That is the close of our case, sir.
PROFESSOR LAWSON: Are you ready?
MR. PAFUNDA: We're rounding them up

right now.
PROFESSOR LAWSON: Let's take a five-minute break, and do y'all --
MR. PAFUNDA: I think it's fair to the panel, we should say, we didn't know when the university was going to end and there's no way to know. We tentatively agreed 3 o'clock, but if I could speed it up, we'd do it before 3:00.
PROFESSOR LAWSON: I think we need to. I don't know how many witnesses you've got, but trying to get through today and tomorrow, get it finished by then --
MR. PAFUNDA: Right.
PROFESSOR LAWSON: -- we need to move and dispatch, and that's all I'm trying to get you to do.
MR. SALSBUREY: Right. And in that sense, Mr. Beauman and I do have other engagements in the afternoon tomorrow.
PROFESSOR LAWSON: Let's take a ten-minute break.

(BREAK TAKEN.)
PROFESSOR LAWSON: Okay. We can proceed again.
MR. PAFUNDA: Professor Lawson, on the record, this is now Dr. Kearney's case.
PROFESSOR LAWSON: Yes, your opening production of evidence by Dr. Kearney. And all the witnesses who are testifying before the hearing panel are being asked to affirm that they will testify accurately and truthfully. On behalf of the hearing panel, may I ask if you will commit to do that in giving your testimony?
THE WITNESS: Yes, sir.
PROFESSOR LAWSON: Proceed.
DR. KEARNEY: Speak loud enough for the court reporter to hear you.

WILLIAM ROSS STRONG, M.D.,
testified as follows:

EXAMINATION

BY MR. PAFUNDA:

Q There's something about teachers, they can't

let it go. But anyhow, would you state your name for the record, please.
A William Ross Strong.
PROFESSOR LAWSON: How do you spell that last name?
THE WITNESS: S-T-R-O-N-G.
PROFESSOR LAWSON: Okay.

BY MR. PAFUNDA:

Q Dr. Strong, how long have you been at the University of Kentucky?
A Almost five years.
Q And I take it those entire five years has been in the capacity as a resident?
A Yes, sir.
Q And your previous educational background?
A I went to medical school at Indiana University; then did undergrad at Butler University in Indianapolis.
Q And as a resident, are you focused in one particular area, and if so, what area?
A General surgery.
Q Why did you select the University of Kentucky?
A Their strong clinical program, operative experience.

Q Was there any particular physicians associated with that program that lured you to the University of Kentucky?
A Initially none in particular.
Q And you say initially. Afterwards?
A Uh-huh (affirmative). Dr. Kearney, one of them.
Q Would you explain to the panel why?
A Dr. Kearney particularly, his personality was very -- is something that I understood. He was very clinically driven, was very active with the patients at the bedside. Also, he held us to a very high standard as a resident as far as requiring the dedication needed to take care of the patients. He was alongside us in that. He --
Q Now, if I may interrupt you, when you say he's alongside of you, you mean literally?
A Yeah, much of the time he was.
Q And that's in what -- for those who may not be familiar with it, in what kind of environment in the Department of Surgery?
A Yeah, both at the bedside taking care of patients in the ICU, as well as in the operating room.

Q And the operating room, what do you encounter in the operating room as a resident?
A You're usually assisting an attending physician with a case. Your graduated autonomy goes up to doing a case with an attending present watching you do the case, kind of helping you avoid pitfalls and things like that.
Q You prefaced your remarks with you are familiar with family members in medicine?
A Yes. My father and grandfather are both general surgeons.
Q And you listened to them?
A Neither one of them wanted me to be a general surgeon.
Q Why not?
A Mostly lifestyle. They -- and that was what drew me to it. They are very dedicated to their profession, and it's one of those things that you see people dedicated at that level, it's very -- it draws you in. And their patient care and what they do for patients is just as much a part of them as anything else they do. And I think that's something that I saw growing up and I liked

and I wanted in a profession.
Q I see. So you wanted to bite into that lifestyle?
A Yeah.
Q Doesn't leave much room for personal matters, does it?
A It does. It's just you have to, you know --
Q Be disciplined?
A Uh-huh (affirmative).
Q All right. Walk us into -- for you as a resident over these five years, walk us into the operating room, trauma. What is the spectrum that you encounter?
A You see everything from --
Q Break it down for me.
A So trauma here, they do a large swath of general surgery. High-end trauma, multi-system organs, you know, you're looking at chest, extremities, belly, pelvis, everything. Patients as acute as actively dying in the ER with active resuscitation. And the ER program here also has a very fertile elective practice, where you do inguinal hernias, appendices, things like that. So it's the broad spectrum both of

patient care as well as stress.
Q All right. When you say "stress," you actually emphasized that word. What stress is associated with it?
A With trauma particularly, you take these patients who are in extremis, who are anywhere between seconds, minutes to death to an hour or so, and they need an intervention now. And as a resident, initially that is very scary. But as you learn the trade, you can identify those instances and act at that time.
Q And do you think you can do that in a five-year period of time?
A I think you can. I think you have to be very dedicated to doing that, know what you're getting into and identify, you know, those things ahead of time that you -- if you want to be trained in a five-year period, I think you can do it.
Q All right. With respect to patients, and this may be stating the obvious, but patients don't necessarily fall into one age group or gender, do they?
A No, no.

Q So you're dealing with children as well as adults?
A Yeah.
Q And when you're in the operating room in that intense, stressful situation, if you would, best as you can, describe what goes on both mentally and emotionally as you operate to save a life.
A I mean, it's very intense. Initially in my training as an intern and a second-year, when you were in there, you were doing less high-stakes tasks, but you're still in the environment and you're just kind of mentally getting used to that environment. Then by the time you're a chief, you're acting in that environment, and that's one of those things that the environment of the operating room kind of goes away. It's all about taking care of the patients, and you're in there and you know what to do and you have to get it done because there's a life at stake. And so it's getting that coordinated care between the anesthesiologist, the fellow residents, the faculty member, as well as the entire OR staff, on that common goal. As the

surgeon in the room, getting that common goal enacted is very important, particularly in a timely fashion.
Q What you've just described, you as the surgeon, do you have to coordinate all that?
A Yes.
Q Explain to me.
A Particularly in multi-system trauma, you bring the patient up from the ER. They're in extremis; they're dying. The anesthesiologist --
Q As the patient comes up from the ER --
A Yeah.
Q -- do you at that point in time, as the trauma surgeon, know what's wrong with the patient?
A No, not always.
Q Right.
A We have a differential diagnosis. When they hit the door, just from their injury pattern, we know the likelihood of their injuries. We assume their care from the time they get there.
Q Okay.
A And we take them from the ER up there with a

general idea, based on our physical exam and rudimentary diagnostics, which body cavity may be involved, what are the important things to explore first in order to, you know, save their life at that point.

Q So this is a team: Anesthesiologist?

A Uh-huh (affirmative).

Q You as chief resident surgeon?

A Yeah.

Q Nurses, techs?

A Yeah.

Q They're all focused on one matter, patient care, correct?

A Yes.

Q And you mentioned something, high stakes. Would this be an accurate statement? You're playing poker with the patient's chips.

A Yeah.

Q So it is the patient that's on the line?

A It is.

Q How good is Dr. Kearney at this?

A Very good.

Q Explain it to the panel.

A Dr. Kearney -- and I get exposed to a lot of levels of faculty as well. He is -- I didn't

know him before five years ago, but he has the innate ability to, whether it's rounding in the unit or in the ER, to identify the problems and clarify the problems down into a -- he knows. He's like, "This is what it is; this is what needs to happen." And he has that experience. As you get on in residency, you start seeing where that's coming from, where he's kind of gotten that experience. But he has an almost innate sense because he's been around trauma so much. He knows this is what this is. And as a resident, you'll get focused on something else and be doing something and he's like, "But the problem is here."

(SOTTO VOCE DISCUSSION.)

MR. PAFUNDA: No, I'm not asking him.

BY MR. PAFUNDA:

Q As a matter of fact, I haven't even discussed this with my client. I'll start off on an easy level. Is he dedicated?

A Yes.

Q Is he professional?

A Yes.

Q Is it his life?

A Yes.

Q Does he swear?

A Yes.

Q Describe -- I take it you've been in many rooms with him --

A Yes.

Q -- many situations over the five years. What triggers it?

A Poor patient care.

Q Explain to the panel because --

A If -- the times where he ends up swearing, and it's hard to just say he, but it's when things are not -- the patient's safety is at stake, whether it's a resident performing a procedure the wrong way or even -- because in these trauma situations, graded autonomy is a large part of our training. It has to be there.

Q Why?

A Because at some point our training ends, and we have to be safe surgeons when we leave residency. And to be able to do that, I think, safely in five years, you have to have graded autonomy. It's part of our national education of standards is graded autonomy.

And I think to be able to do that in general surgery, there has to be -- we all as residents say there's always a little Dr. Kearney in the back of our head telling us, "Don't cut that. Don't do that. As much as you want to, don't do that." And there are certain procedures where the easy way would be to just throw this piece of tissue here, close this hole, just sew it closed, wash it out, be done. But Kearney has told us many times, if you do that, this is what's going to happen two months from now. We as residents don't get to follow our patients for much more than a month, maybe, maybe two months if we're lucky. So we don't see the long-term sequela of some of our operative decisions. And that's where we lean on people with experience to have that. Sometimes we go down this road and by the time we're in our, like, four and a half years, you know, it's not just Kearney yelling at us. Like it's -- I have some opinions of my own, and it could be a little back and forth of, "Well, this is what I think," and he says, "Well, no, this is --

trust me, I've seen this. This is what you need to do." And I think when patient care -- when he sees that the education and the patient care start to diverge is when, you know, he's, like, corrected me.

Q In his own particular colloquial way?

A Sure, yeah.

Q Yeah.

A Which, I mean, it's not -- it's nothing I'm not, you know...

Q There's a patient discussion, and it concerns a [redacted]. Do you recall a Patient [redacted]?

A Yes, sir.

Q Were you in the endoscopy suite when he was being [redacted]?

A Yes, sir.

Q Describe to the panel when you came in the suite what you did, what you observed.

A Uh-huh (affirmative). I came in after I don't know how long they had been there but, the procedure was ongoing. They had already administered his sedation, and one of the junior residents was trying to [redacted]. I was just

picking up the pager from the other chief in the room. I saw they were having difficulty, so I stuck around. And they -- the junior resident proceeded to [redacted], and it wasn't going easily. He was having some difficulty.

Q If I may just interrupt you right there. Is there any danger associated with that [redacted]?

A Yeah. [redacted]. It's not a -- the thing is with [redacted], it's all risk, no glory. It's just like any -- you are just supposed [redacted], and everyone is supposed to be fine. It's no big deal. A monkey could do it. But there's legitimate risks that happen if it's not done properly.

Q All right. Continue on.

A Oh, and so the junior resident was having difficulty [redacted]. I don't know how much time it was, a couple of attempts, and he wasn't [redacted]. And at this point Dr. Kearney asked me [redacted]. [redacted] and

[redacted].

Q All right. How long were you in the suite?

A I would say 15, 20 minutes.

Q How long does this procedure routinely take?

A Less than that, you know. It depends. In experienced hands, five to ten minutes with sedation and everything.

Q And was -- the best of your recollection, your memory, was Patient [redacted] sedated?

A He was sedated.

Q Did you hear at any time Dr. Kearney call him a "fucking quad"?

A No, sir.

Q I'll ask you this. During your five years, have you ever heard Dr. Kearney address a patient in a derogatory manner?

A No.

Q And you've made rounds with him?

A Yes.

Q How many rounds, patients have you --

A How many patients?

Q Yeah.

A I mean, a hundred times -- I mean, we see about a hundred patients a day when he's on service, and that's seven days for a week.

Over five years, do that 12 to 13 months a year? Thousands.

Q Yeah.

A Probably tens of thousands.

Q Tens of thousands. But there's no question, if a resident is out of bounds or a procedure is going incorrectly, the resident will get the brunt of the language?

A Yeah.

Q All right. Do you take offense to this?

A No.

Q Why not?

A I don't view it as a personal attack. It's not malicious. The more I've gotten to know Dr. Kearney, the more I feel like he has a very invested interest in me in becoming what I want to become. On the most selfish level, he will make me into the surgeon I want to be in five years. My goal coming here was to be a surgeon in five years, and I think he does that. And he does it by instilling in us the responsibility to the patient, like not to ourselves, not to the greater good, not to general surgery or academics, but to the patient.

Q Have you had occasion to do, I'll term it, "resident evaluations" of Dr. Kearney?
A Yeah.
Q Does he know what is going on, or is this a secret process?
A It's secret. It's like random, you know, our names are taken off them. This is a national standard throughout ACGME. These have to be blinded evaluations. We do them for all of our faculty.
Q So those blinded evaluations by the residents, that's a national standard which is also here at the University of Kentucky otherwise?
A Yes, sir. We just had our site review a couple of weeks ago.
Q All right.
A No citations. These evaluations don't even come to the faculty until six months after we have filled them out. They're time delayed.
Q Now, with respect to your presence in the endoscopy suite, I mean, are there medical records that would show that you were in the suite and you did the [redacted]? Is that noted in the medical records?

A Typically. I can't remember for this instance.
Q I know that. Let me ask you this. Patient [redacted], when you say he was sedated, there's a difference, is there not, between conscious sedation and unconscious sedation?
A Yes.
Q How did he appear to you?
A He appeared to be -- I mean, for us conscious sedations means he's able to protect his own airway and breathe on his own.
Q Correct.
A He was -- under strict definition, he was under conscious sedation.
Q And the anesthesiologist?
A We administer our own sedation.
Q Do you know how much Versed was administered to Patient [redacted]?
A I don't know off the top of my head.
Q No. If you had to do it over again, would you take a residency under him, Dr. Kearney?
A Oh, yeah, I'd do this all again.
Q You're about to enter the real world in a month?
A Yes.

Q But that's a misnomer, isn't it, because actually the real world is here for you as a student during the course of your residency?
A Yes.

MR. PAFUNDA: That's all.

EXAMINATION

BY MR. BEAUMAN:

Q Dr. Strong, I'm Bryan Beauman. I'm one of the attorneys for the university. Appreciate the time out of your day to come in here and speak to the panel. We have a few questions I want to follow up with you on. Let me just make sure that we're clear: During the [redacted], the [redacted], once at the beginning --
A Uh-huh (affirmative).
Q -- when [redacted]; and then once that's all finished, [redacted] and everything's fine before you close?
A Yes.
Q You came into the endoscopy suite on the [redacted]; you weren't there at the beginning, right?
A I was the one [redacted]

[redacted] for the first time.
Q The first time. So you were there the whole time?
A The whole time of the -- [redacted] until I was --
Q But by the time you entered the room, he was already sedated?
A Yes.
Q So you weren't there when he was struggling with his shoulders?
A No.
Q You weren't there at the time when they had to apply restraints and touching him to hold him still, correct?
A They did have to do that.
Q So you did witness that?
A Yeah, when they had to put him in the light restraints.
Q So that did happen?
A The restraints?
Q Yes. [redacted] was resisting, and they had to restrain him?
A Yeah, yes.
Q So if [redacted] had told someone that that

occurred, he would be accurate in repeating that detail, wouldn't he?

A Under conscious sedation, it would be difficult because it's amnestic, both antegrade and, like, on the back end, so it would be very hard for me to believe. It's like patients say, "I woke up in the operating room." It's very difficult to say that. But if he said this happened, it did happen.

Q You witnessed it, yeah. Were you also present when he was struggling [redacted]?

A I don't know if -- there was a bite block in place when I came in, and they're standard, so I didn't think there was, you know...

Q So whatever happened with that, happened before you walked in?

A Yes.

Q So it sounds like several things happened before you walked in the room, correct?

A Probably.

Q Fair to say there were lots of conversations among everyone in the room that occurred

before you walked in?

A I wasn't there.

Q Right. And you don't know what was said, correct?

A Correct.

Q Have you since learned that at that time Dr. Kearney, and I expect he will admit this when he testifies, called [redacted] a "dumb ass"?

A I didn't hear that.

Q But have you since been told that that happened?

A Like, I've heard a lot of different things, but not that particularly.

Q Okay. Would you seek to emulate Dr. Kearney's behavior in his interaction with staff and particularly with nurses?

A It -- yes. I think one of the things that will bode well for me is that dedication to my patients, and he speaks with patients on a level that they understand. And I'm going to go work with a very rural population that I think understands -- will want me to talk with them on their level.

Q And I appreciate that interaction with

patients.

A Sure.

Q But I'm talking about with the nursing staff.

A The nursing staff respects Dr. Kearney. I mean, if Dr. Kearney says something, it goes well above any other attending and/or resident, so they respect him and his clinical acumen, and I think I would love to have that kind of respect.

Q Have you ever heard Dr. Kearney speak with a nurse who perhaps hadn't met his standard for their care and treatment of a patient?

A Not -- I don't have a clear recollection of it.

Q Fair enough.

A Most of the people we work with, he's worked with for years.

Q Have you ever, on your own accord, had a situation where a member of the nursing staff failed to meet your expectations?

A Absolutely.

Q How did you address that with them?

A As a resident, very carefully. I usually start with some gentle education: "This is why I am asking you to do this." And as a

resident, and particularly in our program, if they are unable to complete that task, particularly in a timely manner, then that responsibility falls on me and I do it myself.

Q It sounds like you would be clear and direct but polite with them as well?

A Yeah. I just tell them. It's not overly cordial or overly negative. It's: "This is the expectation. If you are unable to do it, I will do it myself."

Q Would you use curse words?

A No.

Q Would you tell a nurse that she should wear a colostomy bag over her head because she had shit for brains?

A Again, as a resident, no.

Q Would you do that as an attending?

A No, I would not.

Q When you get out into practice after a few months, would you ever say that to a nurse?

A No.

Q Would you ever call a patient a "dumb ass"?

A It would depend on my relationship with the patient, but not one I didn't know well.

Q So some patients you might call a "dumb ass" at some points in the future?
A I cannot say that I wouldn't. If I said I would not use that phrase in any situation, I would eventually be called a liar.
Q Would you greet a nurse walking into your operating room with the term, "Hey, bitch"?
A No.
Q You mentioned that Dr. Kearney, you've obviously been around his swearing, but you believe it's triggered by poor patient care. Can you give us an example of when you have witnessed those comments?
A Again, it's hard to say. I don't have a clear time. There was a time in my intern year when I was performing a tracheostomy with a chief resident, and during that case there was a serious complication. This is airway complications, and the patient coded. And I remember that we were trying to get the airway established, and we had to pull other residents into the room and get everyone involved to -- there were multiple procedures that had to happen all at one time, and I was an intern, relatively incapable. And I

remember that there was -- I can't remember if there were curse words or whatever, but it was a heated environment to get that patient taken care of.
Q And certainly everyone understands in a stressful environment there's a difference in, you know, dropping a scalpel and saying, "oh," whatever --
A Yeah.
Q -- as opposed to directing it at a resident, at a medical student, at a nurse, at another staff member.
A Right.
Q And I understand there's a distinction.
A Sure.
Q I guess what I'm asking you, do you recall any specific incident where Dr. Kearney addressed profanity at a staff member or at a resident?
A Not a specific -- I mean, I can't give you an example. This is --
Q But you would admit it has happened?
A Sure. I mean, I could admit to you that he has called me -- I would assume he has called me a "dumb ass" at some point in five years.

Have I taken it personally? No.
Q But you would recognize that others would take that personally?
A Potentially.
Q And that would impact their ability to focus on what they're doing?
A Potentially.
Q Yeah. And I think it would impact their ability, whether it's resident, medical student, nurse, or other staff member to communicate effectively as they're treating that patient?
A Potentially.
Q I think they would probably just be scared to speak up, wouldn't they?
A I don't -- the environment in which we work requires stress and requires people to act promptly. And if they're unable to do that, we need to get someone else who can because patients are at risk. As much as we would like it to be an environment where people don't have to raise their voices and people don't have -- sometimes no matter how much prompting or how much clear communication, we have these discussions with the

anesthesiologist all the time across the curtain. As trauma surgeons, not when we, but when we're on the trauma service, we need particular things that they need to do, and if they're involved in an ancillary task or something that is not directed towards saving the patient at that immediate point, we have to address that. And sometimes it's not the most cordial. You're yelling. I mean, there are 25 people in the room, and you have to say, "This is what's important now, we're all doing it now," and, you know, you have to get people's attention.
Q That same stressor doesn't necessarily apply once the procedure is over and you're out in the hallway minutes later addressing performance, correct?
A (Nodding affirmatively.)
Q Can you tell us what would be appropriate behavior at that point when addressing a performance issue?
A Yeah. And interestingly, that incident with the tracheostomy, Dr. Kearney -- you know, I would assume I was visibly shaken by the whole experience. He actually sat me down

and said, "So tomorrow we do three more of these," you know. He at that point -- I mean, he didn't call me a "dumb ass" or, you know, kick me around. He just said, "We're going to do three more of these, and I'm going to be here and we're going to do them together."

Q All right. You had mentioned earlier the national education standards. If you will, there's a notebook on your table.

A Yeah.

Q If you will turn to Tab 12.

A Sure.

Q These are the Accreditation Council for Graduate Medical Education common program requirements.

A Uh-huh (affirmative).

Q I believe this is what you were referring to earlier.

A Yeah, partly. We have a specific one. Is this the one for general surgery, or is this for general ACGME?

Q This is the general ACGME.

A Yes. We have a particular one for each specialty, but this is one.

Q I'll just walk through a couple of these.

A Sure.

Q The headings are a little difficult to follow.

A Interestingly, we went over this, like, two weeks ago.

Q Great. If you'll turn to page 165 at the bottom, and I think there's five or six standards here. About the middle of the page you'll see Roman numeral IV(a), V(e), Professionalism.

A Yeah, yeah.

Q And then under that it says, "Residents are expected to demonstrate," and the first standard there listed is, "compassion, integrity, respect for others"; isn't it?

A Uh-huh (affirmative).

Q On to the next page, which is kind of the next heading "System-Based Practice" --

A Yes.

Q -- if we look at Roman numeral VI(a),V(f)(5) --

A Yeah.

Q It states that, "We're to work as interprofessional teams to enhance patient

safety and improve patient care quality."

A Uh-huh (affirmative).

Q And these are standards you're familiar with, and this is what we were speaking about earlier when we talked about it's critical to have interdisciplinary, interteam, effective communication across all lines at UK HealthCare. You would agree with that, would you not?

A Yes.

Q You would seek to emulate that?

A Uh-huh (affirmative).

Q And that's how you've been trained in your five years, correct?

A Uh-huh (affirmative).

MR. BEAUMAN: That's all the questions I have. Thank you.

EXAMINATION

BY MR. PAFUNDA:

Q Let's just talk a moment about the last little tidbit.

A Okay.

Q Department of Surgery has its own regulations?

A Yes, general surgery.

Q And those are national regulations for general surgery, correct?

A Yes.

Q But no matter what the regulation, let's look at the words that were just recited: "Compassion, integrity and respect for others." Who's supposed to be on top in that list, the patient?

A Yes.

Q So it's compassion for the patient, integrity towards the patient, and respect for the patient; is that correct?

A Yes.

Q And that all boils down to: How good are you at your job?

A Yes.

Q Because that's what the patient wants?

A Yes.

MR. PAFUNDA: That's all. If you will -- are you done?

MR. BEAUMAN: Go ahead.

MR. PAFUNDA: No, are you done?

MR. BEAUMAN: Yes.

MR. PAFUNDA: Yeah, because I was going to ask him to get the next witness.

PROFESSOR LAWSON: Finished?
DR. HAMILTON: Can I ask a couple questions?
MR. PAFUNDA: Yeah, go ahead.

EXAMINATION

BY DR. HAMILTON:

Q I just want to get your assessment. It sounds like swearing occurred. What was the culture just in general in the OR among all the surgeons? Is it just frequent that people are swearing in the ORs?
A Yes.
Q Okay. Are nurses involved in the swearing, or is this more a physician-driven thing?
A No, it's a -- nurses, scrub techs, anesthesiologists.
Q The culture, you would say, in our current ORs here at UK HealthCare over here in Chandler is that people are frequently swearing?
A Yes.

PROFESSOR LAWSON: Okay. Thank you. Ms. Neff, all our witnesses who are testifying for the hearing panel are being asked to affirm that they will

testify accurately and truthfully. Will you commit to do that in your testimony before the panel?
THE WITNESS: Yeah.
PROFESSOR LAWSON: Okay.

CAROLINE NEFF, M.D.,
testified as follows:

EXAMINATION

BY MR. PAFUNDA:

Q Hello.
A Hello.
Q Dr. Caroline Neff, what year are you here at the university?
A I'm in PGY1, so first year.

(SOTTO VOCE DISCUSSION.)

MR. PAFUNDA: Excuse me. He's a control freak.

Q Your educational background, please.
A I went to undergrad and got a Bachelor of Science at the University of Evansville.
Q You're so soft-spoken.
A I went to undergrad at the University of Evansville. I got my bachelor's in biology. And then I went to St. Louis University School of Medicine for medical school and

graduated last May.
Q And you chose the University of Kentucky for what reason or reasons?
A I have a pretty good idea what I want to do when I'm done. I want to go practice general surgery in a rural community. I thought this was a good place to kind of get the training that I needed for that, and it was very geographically appealing too. Those were kind of the big reasons.
Q Family in medicine?
A I have a stepfather who is a general surgeon where I'm from, and then my mother is a nurse and runs his office.
Q And before you came here, your concept or your understanding of general surgery?
A I mean, my dad does everything. He takes care of everyone. He just -- I mean, he works all the time, but it's always because he wants to take the best care of his patients possible. Doesn't complain. He says he has the best job in the world and he would never do anything else.
Q Now that you've completed your first year of residency, are you going to continue down the

surgery path?
A Yeah, yes.
Q Okay. I'll draw your attention back to last year, a patient named [redacted]. Do you recall him?
A I remember [redacted].
Q And would you tell the panel, your first contact with Patient [redacted] involved what?
A My first contact with [redacted] was one morning before attending rounds, the residents always went to see the patient on their own beforehand, and that would have been my first contact with him.
Q And when you say "do rounds," did you then do rounds?
A Yes. And then Dr. Kearney came in, and so Dr. Kearney always sees all the patients, so we proceeded to see all the patients.
Q Now, is that unusual for a faculty clinician, I mean, to go see all the patients?
A Depending on the faculty, yes. All of the faculty will always see the patient at some point, but not necessarily early in the morning. They will always see any patients

that we're -- we have any clinical concern about. But not every faculty member starts off in the morning and says, "Okay, here we go; let's go see everyone."

Q And Dr. Kearney's pattern is to start off every morning with, "Here we go; let's go see the patients"?

A Uh-huh (affirmative), yeah.

Q Do you find that in your training to be useful, and if so, in what respect?

A It was useful for me in that I am very, very early in my training, so I know that if the attending sees the patient and says, "This is what we need to do," I have a very clear understanding of what the plan is for the patient. So when either the patient or the family wants to speak with me or, you know, whatever other resident is there, I have a very clear understanding of what we're doing, what things we're concerned about. And then also a lot of times he'll say, you know, "This is what we need to watch out for; this is what we worry about in particular patients," so then I know what to be ready for. So it's helpful for me.

Q So I take it, during the course of rounds, how often were you and Dr. Kearney in [redacted]'s room? Do you remember? Was it on one occasion, multiple occasions?

A That I recall, one occasion in particular.

Q All right. And in his interview, he mentioned -- he states that Dr. Kearney called him while he was at his bedside, at [redacted]'s bedside, a "fucking quad," and there was a female resident present?

A Uh-huh (affirmative).

Q My question to you is, did you ever hear Dr. Kearney call Patient [redacted] a "fucking quad"?

A I did not.

MR. PAFUNDA: That's all.

MR. SALSBUREY: I don't have any questions.

PROFESSOR LAWSON: Okay.

(BREAK TAKEN.)

MR. PAFUNDA: Next witness is J. R. Taylor.

PROFESSOR LAWSON: Right here, Dr. Taylor. Dr. Taylor, all of our witnesses that are testifying before the hearing panel are being asked to affirm that they will testify accurately and truthfully. Will you commit to do that in your testimony?

THE WITNESS: Yes, sir.

PROFESSOR LAWSON: Proceed.

JOHN R. TAYLOR, III, M.D.,

testified as follows:

EXAMINATION

BY MR. PAFUNDA:

Q You have to state your name for the record.

A John R. Taylor, III. I go by J. R.

Q Why I'm smiling, if I ask you another question, talk a little slower. Where are you from?

A A little bit of everywhere. Born in Fort Monroe, Virginia. Lived in Fort Bragg, North Carolina after that. Lived most of my life in Gainesville, Florida, with a stop in Hawaii and Georgia and Iraq in between there.

Q You are now a fifth-year resident?

A Yes, sir.

Q About, at the end of the month, to step out?

A Yes, sir, 23rd of June.

Q And go where, Dr. Taylor?

A University of Houston for a trauma/surgical care/critical care fellowship.

Q And I take it that's the field that you're now specializing in?

A Yes, sir.

Q And you have been here for the entire five years?

A Yes, sir.

Q With Dr. Kearney?

A Yes, sir.

Q Would you tell the panel your interactions as a resident with Dr. Kearney, his approach to patient care, and his approach to residents?

A I think Dr. Kearney is -- the first time I met Dr. Kearney, he interviewed me here when I came. We share a common interest of Florida Gator basketball. Of course, Billy Donovan used to be his neighbor, and having grown up in Gainesville most of my life, I think we talked about basketball for about 20 minutes. Then at that point in time, at the end of the interview, he just kind of looked at me and said, "You'll be fine here. You'll be fine wherever you want to go." I have worked with Dr. Kearney for every month that

I've been on trauma. I've worked with him on one of the other general surgery rotations that I've been here. He's one of the best, if not the best, teacher that we have for clinical stuff. He always has the patient's best interest in mind. For the rest of my life, I'll always remember him saying that we make decisions with the patient's chips, not with chips that are ours, and that we always have to keep that in mind that we're the people that take care of these people, but it's ultimately the patient's chips that are on the line. He's taught me more things in and out of the operating room than any other person that's here. They're things that I'll carry on when I go do my trauma critical care fellowship that he's taught me, from simple technical things to actually caring about the residents and continuing to sit down and teach them, you know, after rounds. There's so much emphasis now on, you know, length of stay and notes and documenting and stuff like that, that I think we lose track of the ability to teach residents, and that's what goes on the wayside. He always sat down and

talked with us, and for other reasons he will be near and dear to my heart. [redacted] he's the only attending that came to my house. He's the only attending that brought stuff for my wife and I. He's the only attending here who asked every day, when I talked to him, about my kids, our two other kids that we have. He still asks about them. And I know, even though he's never told me, I know that he shares a common loss in losing his wife and had to deal with raising children after that. And while he's never said that to me, [redacted] and having to move forward when life isn't fair and life isn't easy, but we have to keep doing what we do. So for reasons outside of being here, he will always be near and dear to my heart.

Q And, Dr. Taylor, you hold a position as chief resident?

A Yes, sir.

Q And your background, you mentioned it; you just mentioned it in passing. I take it you're a veteran?

A Yes, sir.

Q Served in Iraq?

A Yes, sir.

Q Saw combat?

A Yes, sir. I was a -- from '02 to '06, I was an infantry officer in the United States Army. I deployed to Iraq in January '04 to February of '05. For the first nine months, I was light infantry platoon leader, and then for the last four months I was a company executive officer second in charge of a light infantry company in Iraq.

Q And after that tour, to state the obvious, you decided at some point to become a trauma surgeon?

A Yes, sir. I was an orderly in the operating room in undergrad, so I was always exposed to surgery.

Q That will make you be a trauma surgeon in a heartbeat, right?

A Yeah, but...

Q Explain to the panel, you come out of combat and now you want to be a trauma surgeon; in fact, you are a trauma surgeon?

A Yes, sir.

Q I apologize. Tell the panel why.

A It's about the only thing -- it makes me come

to work every day. I mean, it's as close as you can get. You can be -- as Dr. Kearney would always say, you can operate and be the best person to operate, but you can do everything afterwards and be the best medicine doctor for the patient afterwards. You can take them from the operating room to the ICU to the floor and get them out of the hospital. So you see them from the time they hit the door to the time they leave, and you can be the best at both. A lot of people are great surgeons, but they can't do the critical care stuff on the back end. A lot of people are great at critical care, but they can't operate. For what we get to do, we get to do both, and I would like to think, with everything that I've seen in my life, that there's probably not any situation that comes across that gets me too terribly excited and that I would be able to make quick decisions in times when people need it. It's what appeals to me. I always knew this is what I wanted to do. I just had to prove that the other things weren't for me, so...

Q Do you feel you're going to make a mark?

A Yes, sir. I owe it to the guys, yeah. I owe it to the guys I served with. I owe it to the people who have trained me.
Q Explain to the panel why.
A You know, I had buddies that -- Memorial Day was on Monday. A lot of people forget what that's for. I've got buddies that I think about, buddies that didn't make it home, buddies who committed suicide when they got home. And I owe it to them for what they did for me to give it back to somebody else. And I think the best venue for me to do that is as a trauma surgeon.
Q With respect to trauma surgery, how stressful is it?
A I mean, it's stressful, but it's not as stressful as other things I've dealt with.
Q I understand that.
A I mean, the beauty of it is, is we make a big deal of what we do. I get it, and I make decisions with other people's lives on the line. But I know what it's like to make a decision where my life and 38 other guys' lives are hanging in the balance, as well as, you know, civilians and stuff like that. So,

yeah, is it stressful? Sure. But after making it through Ranger school, I know a physical and mental stress level that's a little bit different. No offense to anybody in this room.
Q With respect to Dr. Kearney, and I'll use the euphemistic phrase, he uses off-color language?
A Yes, sir.
Q Do you find it offensive?
A No, sir.
Q Why not? Explain to the panel.
A It's always been directed at me. It has always been in situations where I have to perform better. There are numerous times in the middle of the night where you're trying to save somebody's life who gets crunched in a car accident where, you know, he knows that you need a sense of urgency, and sometimes people don't get it, you know. And I think he also knows that for me personally, I respond to that without any problem. I mean, I grew up with that. I think we all sometimes lack a sense of urgency, but I think it's never done in jest. It's never

done to ridicule. It's always done to get you to be better. And the beautiful thing about him is he might ride you the whole case, but when he tells you at the end of the case you did a good job, it's not just blowing smoke. It actually means something to you.
Q As a chief resident, what about the other residents, their opinions of Dr. Kearney?
A Oh, I think universally we have a group of, you know, 30 residents. I think to say that all 30, you know, think he hangs the moon, I think wouldn't be telling the complete truth, but I think universally he's regarded as one of the best teachers we have. Technically, he's one of the best people to operate on -- to operate with. He teaches you things every time you operate with him. It's no secret that when a very complex general surgery case comes in or someone who we deem to be a bit more important than someone else in the hospital comes in and needs an operation, he's the one that did it. He's the one that, you know, other services would call to, you know, to help out when they have things that

are problems. And I think the residents value his input. They value working with him. And, I mean, I'm disappointed I haven't been able to do my last two months in trauma without him being there.
Q Do you think patient care suffers?
A It does.
Q Tell the panel how.
A Outside of being a resident, Dr. Kearney teaches the medical students every day, you know, on the general surgery rotation. He's done this for a long time. If you talk to any of the medical students that have gone through the general rotation, they always remember what he teaches them about. He helps them review for the tests. He also, you know, teaches you a little about life too. I think part of my perspective is a little different, having lived a different life. I kind of see the world a little bit differently. I didn't go all the way through school like a lot of these kids do who don't really know. You know, the hardest thing that happened with some of these kids is they lose their iPad charger. So, you know, he

instills that there's something else out there. He asks them to read things that are outside of medicine. He's the one that talks to them. There's a plastic surgery resident; his last name was Nimitz. And Dr. Kearney told me he called him Chester one day, and the kid had absolutely no idea what that means. So, you know, what we would lack in world knowledge, you know, he's not there for that. He's always there for the residents. He always teaches the residents. He'll teach in the operating room. He's there for the fellows. He's the one that the fellows call. I mean, we still call him when we have complex things to do. I mean, we took an IVC filter out of someone's duodenum the other day, two residents and I with an attending standing over our shoulder, and me and one of the other guys talked to him about it beforehand: "Hey, what would you do in this situation? Is there anything different you would do?"

Q Do you know that they put out a directive that he's not supposed to speak to anybody?

A I saw that, yes, sir. Yeah, I mean that's

the --

Q So when it came to patient care, the patient care actually came first?

A Yeah, oh, yeah, always. I mean, to say that we -- as I've told you, to say that we can't talk to someone or we need to go through the hospital lawyers to talk to somebody beforehand is a little shocking to me. To say that that e-mail --

Q Wait a second. What e-mail are you talking about?

A There was an e-mail that was forwarded to us through the GME office requesting that we -- if we have any interaction with Dr. Kearney, that we request that hospital people be present for the -- or hospital counsel be present for that. You know, when you start getting into legal things, when you're a physician, you don't really understand that realm. I had residents that came up to me that were very concerned: "Hey, you know, I still call him and ask him questions. Do I need to have a lawyer to talk to him about those things? Do we need -- you know, what do we have to do in this situation?" It's

very nebulous, and it caused a lot of people a lot of heartache because that's just outside of the things we do. The way I think about it would be like you coming in the operating room and me talking to you about a complex operation. You'd have no idea, and you'd be uncomfortable with some of the things that we say. But when we start getting around legal things, that's just not what we do; you know what I mean? So I think a lot of the residents perceive that as being -- not really knowing what to do with it. Take a step back. They seemed a bit threatened by it.

Q You mentioned they were threatened by it. Were they intimidated?

A I think so. I mean, to say that we had to talk to an attorney before we could talk to another person in my opinion steps over the bounds a little bit, to say the least, given freedom of speech and other things that we believe in. I thought that was a little bit off. Plus, I didn't like the fact that, if that's really what we wanted -- I think nowadays we hide behind e-mails and text

messages. If somebody really wanted that, they could have come and said something. We are always together twice a week. They could have said something to us as a group if it really was that important. But to kind of do it in an e-mail in passing seemed a bit problematic.

Q Did Dr. Zwischenberger come to speak to you directly?

A He came to me in the operating room one day.

Q Let me ask you this. Does he come to the operating room?

A No, sir.

Q When you say no, does he ever come to the operating room?

A I've done four months, five months of CT surgery since I've been here, and I think I've been in the operating room with him twice.

Q He came to the operating room. What happened?

A He was looking for me and Ross. As a chief resident, you kind of hold sway over all the other residents, and they -- I mean, they are the ones that elect us into this position, so

they listen to us. And we all kind of knew what was going on, you know, in the background with Dr. Kearney. And so, you know, he wanted to let me know that we should avoid getting involved with Dr. Kearney, we should do our best to stay out of the situation, that these situations get very muddy and they can get ugly. I don't remember specifically the words that he said, but the message was in essence to not get involved, to kind of back away, and that, you know, people's careers can be hurt in situations like this, so...

Q He specifically mentioned people's careers can be hurt?

A Yeah.

Q You stepped forward?

A I don't really believe it. I mean, you know, he always put the patients first. He always put us first, you know. You know, I -- I don't think my career will be hurt by specifically telling the truth about, you know, Dr. Kearney, his influence on me, and his influence on the patients and the medical students and the residents in this

university.

Q Thank you.

A You go anywhere in this town and you ask them, as I unfortunately had to, you ask people in other professions about who you would want to take care of you when you come to the University of Kentucky, and his name was always said. If you're in the trauma bay, he's the one. He's the one the residents want. He's the one that, when the VIPs come in, he does the operating.

MR. PAFUNDA: Thank you.

PROFESSOR LAWSON: Mr. Salsburey.

MR. BEAUMAN: No, Mr. Beauman.

PROFESSOR LAWSON: Mr. Beauman.

EXAMINATION

BY MR. BEAUMAN:

Q Very obviously, you look up to Dr. Kearney as a mentor?

A Yes, sir.

Q You don't want to see anything negative happen to him or to have any bad outcome or consequences from this proceeding, do you?

A No, sir. I think my time here is done. I won't be coming back. I feel sorry for the

people that come back after me that don't get to work with him.

Q I assume you're unaware of the situation that led to this proceeding?

A I was not involved at all. I wasn't on the trauma surgery service at that point in time. Of course, you know, as things have escalated, I've been made aware of the situation.

Q Have you talked to Dr. Kearney specifically about what happened?

A Specifically about what happened on the day? I've never asked him what happened or what transpired.

Q Did he volunteer to you what happened?

A He just said there was some -- there was an incident in the endoscopy suite. But outside of that, we have never talked specifically about the details.

Q So you don't know what was said, and it was never reported to you what was said?

A Only through back channels and hearsay. It's never come from him, specifically.

Q Okay. So what were you told?

A That at some point in time he said during the

procedure -- and, of course, this is coming from three or four links down the telephone game from this -- that he said, "Hold still, dumb ass," you know. As I understand it, the kid was a quadriplegic, [redacted], and he had had [redacted], [redacted] people for this procedure. And, you know, one of the problems we have is if they don't get enough medication, they bite down on the -- even with a bite block, they can bite down on the [redacted].

Q Well, and saying that to a patient, "Hold still, you dumb ass," would that be professional behavior in your opinion?

A I think in light of the situation, I would say that it can be perceived as not being professional. We all have worked with him enough to know that these type of things aren't meant to hurt, but they're meant to relay his message.

Q But that's directed at a patient. That's a little different than your experience.

A But at the same time, I'm not sure if that's

even what was said. I mean, I'm three or four people away from this, so I'm just telling you, I wasn't there, so I can't tell you if he actually said that.

Q Would you repeat that type of statement to one of your patients in a procedure you had in the future?

A With what I am going to do, I cannot tell you that at some point in time in my career, with the type of people I'll deal with, that those words might not come out of my mouth.

Q I think you would certainly strive not to do that?

A We would all shoot for that. But I can tell you, anybody in this room that tells you that they haven't, you know, with what we do...

Q I assume you are unaware of any prior complaints against Dr. Kearney that predate that?

A No, sir.

MR. BEAUMAN: That's all I have. Thank you.

EXAMINATION

BY DR. HAMILTON:

Q Question. So you certainly come back -- come

from a military background?

A Yes, sir.

Q Command-and-control-type approach --

A Yes, sir.

Q -- where there typically isn't disagreement up. Do you feel comfortable disagreeing with Dr. Kearney?

A Uh-huh (affirmative). I've told him that too.

Q Good. Okay.

A The other thing about that, too, is, you know, his way isn't the only way, you know. I mean, we have other good attendings who do things differently. Dr. Roth, who he trained, does things a little bit differently than he does. Dr. Chang, who he trained, does things different with complex hernias. Sometimes you would say, "Hey, Chang does this. What do you think about this?" Things like that. But from what I have done, I wouldn't ever have a problem with telling him, "Hey, do you think we should do this?" Most of the time he's -- well, almost uniformly he's right.

Q Okay. And would you say right now, over here

in Chandler's OR, the culture is one of it's common for people to swear?

A Yes, sure.

Q Is this exclusive to physicians or nurses?

A Everybody.

Q Everybody?

A Everybody. I mean, I know that I have been told that there are certain words in my vocabulary that I shouldn't use, and I strive not to use those, given that I have a soon-to-be [redacted]. But I can tell you this isn't combat, but when it gets real hairy real quick, people listen. Sometimes you've got to raise your voice. Sometimes you've got to say things people are uncomfortable with. But, I mean, we're talking about people's lives on the line.

DR. HAMILTON: Thanks. Appreciate it.

PROFESSOR LAWSON: Do you have anything more, Mr. Pafunda?

MR. PAFUNDA: No, I have nothing further.

PROFESSOR LAWSON: Do y'all want him to send another one in?

DR. KEARNEY: [redacted].

MR. PAFUNDA: [redacted] please.

(BREAK TAKEN.)

PROFESSOR LAWSON: [redacted], we're asking that all of our witnesses who are testifying before the hearing panel today affirm that they will testify accurately and truthfully. On behalf of the hearing panel, I ask if you will commit to do that in giving your testimony.

THE WITNESS: I will, sir.

PROFESSOR LAWSON: Okay.

[redacted]

testified as follows:

EXAMINATION

BY MR. PAFUNDA:

Q [redacted], you have to state your name for the record.

A It's [redacted].

PROFESSOR LAWSON: Speak up a little bit.

MR. PAFUNDA: You did when you entered. You want to repeat that? You have to speak up in here. In the room,

the sound gets lost, and the panel needs to hear.

BY MR. PAFUNDA:

Q [redacted], there's a document in that notebook, but you conducted an interview of Patient [redacted]?

A I was called to his room to speak with him and his mother.

Q Would you tell the panel what triggered it, what brought you to his room to speak with his mother?

A Well, I am the nurse manager for the Trauma and Surgical Tower 100 on the seventh floor, and [redacted] was a patient there, had been in my ICU, and then had also moved down to progressive care area. And there had been several different occasions when his mother had voiced complaints or had concerns. And as part of our Service Excellence Program, the nurse managers round, and we try to follow up on those issues to make sure within our control what we can do. So I was initially asked to come to the room by his mother. She had concerns.

Q All right. And when you were initially asked

by the mother to come to his room, had you been aware that she had been making complaints since his arrival or admission here at the University of Kentucky?

A I was. There were several occasions where she had also gone to our Service Excellence Department and lodged complaints at that point, and those complaints then are sent back through the system and had arrived back to me at different occasions.

Q This is a little bit off track, but when you say "back through the system," number one, I take it upon his admission these complaints started to be generated by his mother about his care; is that correct?

A I can only speak to the time for when he was in my unit.

Q Which is ICU?

A Yes. And he began in my ICU, and she had several complaints during that length of stay prior to him moving out to the progressive care area.

Q Her complaints, had they been recorded or noted or cataloged someplace where I could go find them?

A The Customer Service Department keeps records of those different complaints.

Q And if you recall, were her complaints about the treatment of her son while he was in ICU?

A They were not specific to the treatment. She had concerns about different staff members, nursing staff, very -- I'm looking for the right word --

Q Just say it.

A They -- they were very minuscule. Not to her, they were important to her, but as far as things that we could resolve and the complaints that were there, there was very little we could do or that I could do other than just to allow her to voice her frustrations.

Q Do you recall who the attending physicians might have been while [redacted] was in ICU?

A Well, our trauma team was part of those, and the neurosurgical team was involved there as well. I can't give you specific names without going back to the record.

Q But I take it at some time after his admission, at least within the first three days, someone should in all likelihood inform

the mother that he was quadriplegic?

A Yes, sir, that would have been the expectation.

Q And whether his mother accepted that or not is a whole other question, correct?

A Correct. I feel confident that that information was shared, but that she didn't hear it, wasn't ready to hear it, and may -- we'd see that repeatedly with different patients. They're just not ready to accept, and there's always that hope that this will be the miracle case that something is different.

Q Did you know that while he was in the hospital he had hired a lawyer?

A I did not know that specifically, other than -- and I can't give you the time frame, but there was an attorney who presented himself onto the unit. This was not in the ICU. This was after he had moved down to the progressive area and had asked and inquired about the location of the patient, and in trying to find the mother and the patient, told the staff that "I'm his attorney for the car accident" --

Q Okay.
A -- or "the accident."
Q Okay. Moving on, I take it you spoke with the mother about her complaints about Dr. Kearney; is that correct?
A I went and asked the mother, told her that I had been told she'd like to talk to me, asked her what her issues were in the presence of the patient. He at that time was [redacted]. He had very little to say, and I allowed her to tell me what the issues were. At the initial conversation, there was no physician named. Dr. Kearney's name was not specifically mentioned at that time. She told me that her son had gone down to endo to get his [redacted] and that there had been issues and that the gray-headed physician -- this is what he had told her, the son had told the mother 12 hours post. She said when he came back from the procedure, he was nauseated. The nurses got him something for that. He was anxious. I could see he was anxious, but he wouldn't tell me what was going on until later that night, the next day. Then he said, "This is what happened."

I finally got him to open up to me.
Q All right. When you finally got him to open up to you, this was after he identified the physician as gray-headed, correct?
A Correct, sir.
Q Would it have been your opinion at the time, when he said "gray-headed," he meant full head of gray hair like Professor Lawson --
A To be honest, I didn't give any consideration to it. It was a gray-headed physician, and we have lots of gray-headed folks walking around different days, myself included, although I'm not a physician, so I try not to think about it.
Q Good to know, some of us that are gray-headed are wandering around. But anyhow -- all right. So you went back a second time to the mother, and did you speak with Patient [redacted] at that time?
A I did the following -- actually, I was -- as I -- he chimed in occasionally, but the mother primarily did the talking. And then later down the road Mr. Iler and Ms. Pisacano and Dr. Boulanger came to speak with the patient.

Q Now, when you say "later on down the road," were you still in the room talking with Patient [redacted] when they entered, or was this several hours --
A That was the following day.
Q All right. So to sum up, you were there on three occasions, two with the mother and one with the patient. Then a third occasion, the third occasion with Mr. Iler, Margaret Pisacano, and Dr. Boulanger?
A Correct.
Q In Dr. McDowell's interview, you told Dr. McDowell that Patient [redacted]'s story seemed to grow; is that correct?
A Correct. From the first encounter that I had with, again, the mother primarily speaking, although the patient would nod, again, there was no mention of Dr. Kearney's name. There was the story about that he was nauseous, he was anxious. There was mention that "The person who had come to get consent, the doctor who had come to get consent, had told us and promised us that he would be asleep, but that he woke up." The mother also said that [redacted] had eventually shared with

her that when he woke up, there were people around him and that someone was actually laying across his legs holding him down.
Q And you didn't take notes of any of these conversations?
A I did not take notes at that time.
Q And when you say "the story seemed to grow," would I be able to characterize that correctly by stating it appeared that somebody might be feeding him the story?
A When the story came to grow, it was much more detailed of things that I could not validate one way or the other as being factual. There were names associated with the story as far as "Dr. Kearney did this; Dr. Kearney said that." So, again, this did not -- the events did not occur on my unit, so all I had was what I was initially told by the mother and then as I went back the second time how the story had grown.
Q So I would be correct in stating that the story was being fed to him?
A I don't know where these other details came from.
Q All right.

A They weren't present the first time, and they were not details that I knew about.
Q Did you voice your opinion to university counsel and Dr. Boulanger that the story seemed to grow at that time?
A At the time that Ms. Pisacano and Mr. Iler and Dr. Boulanger came to interview the patient, I stood in the room and overheard and observed the contents. I made no comment whatsoever at that time. Once they stepped out of the room, I did speak to Ms. Pisacano and I believe Dr. Boulanger, but I know I told Margaret, "That is much different than the story I heard 12 hours ago. There were no names when I heard this before."
Q And your title is what?
A I'm a patient care manager for the trauma surgical ICU and seventh floor Tower 100.
Q Your job duties include what?
A My job duties include --
Q What do you do?
A I have basically 24-hour responsibility as the patient care manager for what it says, for the patient care, the nurses, the techs, the clerical staff, facilitating that for our

families, making sure as much as I can within the practice of nursing that their needs are met.
Q And you've held this position for how long?
A I have actually been in this particular position since 2008. Prior to that I was also a manager but of a different unit, the clinical decision unit as it opened back in 2005, and prior to that with the air medical service for 15 years as far as the assistant chief flight nurse, managing chief flight nurse.
Q Here at the university?
A Yes, sir.
Q You've been with the university how long?
A Since 1986. Here comes the gray hair again.
Q Is this the first patient complaint about Dr. Kearney in your experience?
A Directly from a patient, yes, sir.
Q Yeah. And you've known Dr. Kearney for how long?
A Since he came to the university a couple of years after I did.
Q Is he professional?
A He is ultimately professional. Sometimes his

approach and his verbals come out as other than what is the norm of professional, but whatever is there, whatever is said, it is always with the patient's best interest at heart. And the staff, my family, if I need a surgeon, that's who I want taking care of me.
Q So since he's been gone, do you think patient care has suffered?
A I think that we have some other capable faculty members. However, the trauma surgical service feels like it's not as cohesive. The nursing staff have voiced to me that they don't feel like they get the same level of support. They don't get the, if you will, off-the-cuff education. They knew if they had issues and they thought there was something going on with their patients, that it didn't matter the time of the day or the place, they could contact Paul Kearney and he would come and take care of the issue.
Q So the nurses want him back?
A They absolutely want him back.
MR. PAFUNDA: Thank you. They're going to have some questions.

EXAMINATION

BY MR. BEAUMAN:

Q [redacted], you would agree with me, if I understand what you've just testified to, that at times Dr. Kearney's behavior is not professional?
A I would say that there are times when Dr. Kearney's behavior, or at least his -- let's just put it out there -- his cursing is outside of what is standard consideration of professional, but we all have a definition of professional. So other than the occasional curse word, otherwise, his practice is absolutely professional.
Q In fact, you told Dr. McDowell and Dr. Bezold, who were investigating this on behalf of the Medical Staff Executive Committee, that his behavior has not always being professional?
A Within those guidelines, I probably did say that, yes, sir.
Q And in fact, I think I understand what you're saying; many of UK personnel may drop some profanity, but what I think I just understood you to say is Dr. Kearney goes above and

beyond with his use of profanity than what others do?
A No.
Q Okay. I thought that's what you just said.
A No, sir. I would say that Dr. Kearney uses profanity. I would say that 99 percent of the other physicians, surgeons, and others use profanity at one time or the other in the practice environment.
Q Okay.
A Sometimes not even justified from others.
Q Now, are we talking about the "We're frustrated and we let something slip," or are we talking about looking at someone and calling them names like a "fucking moron" or language like that?
A I have never witnessed Dr. Kearney look directly at someone and belittle them or call them an "F'ing" et cetera and so on. I have over the years had disagreements with Dr. Kearney face to face. We didn't agree, but whatever the message was he conveyed, it was something that I needed, and that's speaking from personal. And it was, again, putting the patient first. If I had missed

something in nursing practice that needed to be right for the patient, that's what he was upset about.
Q Are you aware that other nurses have complained that he has spoken to them with similar types of language?
A I have not had any of my staff over the course of the years complain about that.
Q But you don't dispute the complaints that have been made against Dr. Kearney?
A I'm unaware of other complaints, sir.
MR. BEAUMAN: Fair enough. That's all the questions I have. Thank you.
MR. PAFUNDA: I have nothing.
DR. KEARNEY: Dr. Hansen has a question.
EXAMINATION
BY DR. HANSEN:
Q In your practice environment in the ICU -- I'm talking about nurses -- do nurses cuss?
A To each other.
Q Okay. To the doctors?
A I would say it occasionally happens.
Q Okay.
A Because our -- although our nursing profession has grown and there are more

males, and I hate to be stereotypical, but that's what it is. There are more males using profanity more regularly than the female generation of the nurses. So it happens, yes, not as frequently.
Q Is it an everyday occurrence?
A At one point or another, yes.
DR. HANSEN: Okay.
PROFESSOR LAWSON: Any other questions?
EXAMINATION
BY DR. HAMILTON:
Q Yeah. I just want to ask a little more detail around those three meetings that you had with the mother and the patient. This is at least important to me. You said the first time you talked around this was because the mother was complaining. This is, again, the meeting after the [redacted]. So you said the mother was only speaking; the patient was anxious, nauseated, didn't mention this gray-haired physician, and that he had woken up during surgery with someone laying across his legs. What else was mentioned during that first meeting that they voiced complaints about? What did they

complain about? Just the fact that he had woken up, or what else?
A Her primary focus was that they had been assured that he was asleep, that he would be asleep. He wasn't. He woke up. She said that he told her that when they were trying to [redacted] that that's what had awakened him, he had been asleep, but as they [redacted] and that's what woke him up. He could see people standing around his bedside. I really don't remember much.
Q Of her saying anything else beyond that?
A Much more than that, no, sir.
Q And then the second meeting, what did it expand to?
A At that point it expanded to Dr. Kearney had come in the room. There was -- there was a resident who -- there was something about "It's there, just go on and do it," and someone else had to step in for the person. And, again, those were described as residents. They weren't described as any names. She said that Dr. Kearney was -- had asked how much -- how much has he had in

reference to him being asleep and sedation.
Q And what else about that second meeting did they raise as issues?
A She voiced and he said at that time that Dr. Kearney had been overheard out of her -- out of his room at some point during the stay saying that her son was an "F'ing quad." That was overheard. And she said, again, about laying across the lap. That's what I've got.
Q So the mother stated that she had heard someone say that they had overheard Dr. Kearney say he was an "F'ing quad" or she had overheard him saying this?
A To my best recollection, the mother was saying she had overheard this.
Q Overheard him saying that?
A (Nodding affirmatively.)
Q On this second visit?
A Again, that detail --
Q Prior to this?
A -- had nothing there.
DR. HAMILTON: Okay. Thanks.
THE WITNESS: And she was not specific about when she had heard that or...

EXAMINATION
BY DR. HANSEN:
Q Would it have -- the only place -- I'm asking this: Perhaps the only place she could have heard it would have been on the unit?
A I don't know.
Q Because she wouldn't go to the endoscopy suite or the pre-op suite?
A So the mother had walked around the different areas and was outside of the rooms, had asked different staff members some probing questions about who was here and who was taking care of her son, but I have no idea of where. I mean, it certainly could have been in the ICU. It could have been on the progressive care unit. I honestly have no idea, and she gave me no indication that I can recall of where she thought she heard this.
EXAMINATION
BY DR. HAMILTON:
Q But she said she herself heard this? She didn't hear staff saying they had overheard Dr. Kearney saying this as she was wandering around basically questioning people?

A My recollection of what she said was she thought she had overheard him say --
DR. HAMILTON: Okay, great. Thank you.
DR. HANSEN: One last question.
EXAMINATION
BY DR. HANSEN:
Q Did her son -- I know he was [redacted] and perhaps speech was limited, but did he complain of overhearing that he was an "F'ing quad"?
A On the second meeting, her son was able and not the -- to my recollection, he didn't say "fucking quad." He said he had been called an "F'ing idiot."
Q So that's what he had heard at some point?
A That's the -- again, that wasn't present in the first story. That was more the detail that came about the following day with who had said and what they said.
DR. HANSEN: Okay.
EXAMINATION
BY DR. HAMILTON:
Q And, again, at the third meeting, after you and Dr. Boulanger and Margaret Pisacano and Iler left the room, you mentioned to them

that the story had evolved to Margaret?
A To Margaret.
Q To Margaret.
MR. BEAUMAN: Can I just follow up on that?
PROFESSOR LAWSON: Go ahead. EXAMINATION
BY MR. BEAUMAN:
Q I may have gotten myself confused, but when you say the third meeting, the third meeting is the one you referred to with Dr. Boulanger when he conducted the interview?
A Correct, when I stood in the room, yes, sir.
Q Okay. So the first meeting was only receiving communications from the mom?
A Correct, although it was in the presence of the son.
Q And the second meeting, [redacted] was speaking?
A [redacted] and Mom spoke.
Q Yes. And you reported the details of that meeting to Margaret Pisacano?
A I did.
Q And I think at that time you reported that [redacted] told you that Dr. Kearney persisted in using expletive-laced language,

making statements that he would not put [redacted] to sleep for this procedure and nothing would touch him anyway; isn't that correct?

A I do not remember that specifically, sir.

Q All right. Did [redacted] not report to you at the time he felt trapped and helpless in the procedure?

A He did say that he felt trapped when someone was laying across his legs.

Q You reported this, though, to Margaret Pisacano?

A I did call her.

Q So you related to her and tried to be as accurate as you could what you had just heard from [redacted], correct?

A Yes.

MR. BEAUMAN: That's all.

MR. PAFUNDA: One question.

EXAMINATION

BY MR. PAFUNDA:

Q Where's [redacted] from? Do you know?

A I don't, sir, not without looking at his record, not specifically an address, I don't.

MR. PAFUNDA: Okay. That's fine.

PROFESSOR LAWSON: Okay. You want her to call your next witness to come?

MR. PAFUNDA: No, and you want to know why?

PROFESSOR LAWSON: You want a break?

MR. PAFUNDA: No. He was standing right outside the door.

DR. KEARNEY: Dr. McGrath, yeah, grab Dr. McGrath.

(BREAK TAKEN.)

PROFESSOR LAWSON: All of the witnesses who are testifying today were asked to affirm that they testify truthfully and accurately. On behalf of the hearing panel, I ask if you will commit to do that in giving your testimony.

THE WITNESS: I will.

PATRICK MCGRATH, M.D.,
testified as follows:

EXAMINATION

BY MR. PAFUNDA:

Q Dr. McGrath, will you state your full name for the record, please.

A Patrick Charles McGrath.

Q You presently hold what position within the Department of surgery?

A Chief of general surgery.

PROFESSOR LAWSON: Dr. McGrath, please speak up.

BY MR. PAFUNDA:

Q We haven't moved to them yet, but in order to make sure this proceeding moves rapidly and smoothly and is completed within two days, you've done performance evaluations on Dr. Kearney; is that correct?

A That is correct.

Q And at least signed off on them; is that correct?

A That is correct.

Q For how many years, over what period of time?

A That would be just about ten years.

Q During that ten-year period of time, without referring to the performance evaluations specifically, have all his evaluations been in the excellent arena?

A Yes.

Q And in that regard, is he also designated in those evaluations over that ten-year period of time as professional?

A I'd have to look and see, but that's one of the columns, and I think it is.

Q And likewise, he's recognized as an excellent teacher; is that correct?

A That's correct.

Q When I say teacher, teacher of residents?

A And medical students, correct.

Q Do you know anything about this Patient [redacted] incident?

A Thirdhand, so it filtered down to me long after, so it is truly thirdhand.

Q No, I understand that. I was just curious if you might have had some contact with it one way or the other. And your general duties are what, Dr. McGrath?

A Well, I guess primarily I'm still an active surgeon that, you know, operates three times a week and sees patients two days a week but runs the division in terms of recruiting faculty and maintaining the divisional structure and sort of making sure things run efficiently and sort of providing oversight for the division, you know, that's within our department.

Q And over that ten-year period of time, I take

it, based on his performance evaluations, Dr. Kearney has been an integral part of the division?
A He has.
Q Would you explain to the panel in what way?
A Well, I mean, I'm sure they know he built the trauma division here from sort of nothing.
Q When you say he built it, I don't --
A I mean, it was rudimentary when we came, back in 1988; and, you know, that year, the year before, there was one trauma surgeon who left shortly after we got here, and then Dr. Kearney took over and built the program to what it is now, which is a nationally recognized Level 1 trauma center.
Q And in fact, it's ranked third in the nation, is it not?
A I don't know the statistics, but I wouldn't be surprised.
Q And with respect to its national ranking, you say he was instrumental in it?
A Well, he was the -- he was the, you know, director of the trauma program, and he was the section chief, and so he was sort of in charge of all components of it and helped

with the recruitment and training of the current faculty that are there now, a lot of them.
Q And in that respect, for those who are not, particularly myself, but not familiar with it, what does it take to build a trauma center up to the point that it's nationally recognized?
A I mean, it takes a lot of hard work. It takes organization. It takes a lot of knowledge of the whole trauma system. And this isn't just trauma; it's trauma and critical care. We kind of combine them in the same thought process. But it takes, you know, a unique individual that has the capability of providing leadership, as well as having the knowledge and the clinical skills to also be an effective, I guess, director of that whole system. It's a lot of work and setting up the whole trauma, you know, office so they can capture all the data and then providing -- you know, having research and education associated with it.
Q And as you noted in your earlier comments, it's gone from one surgeon back in the day --

A Right.
Q -- to how many now?
A Well, right now I think we're up to eight or nine.
Q And the fact that it's a Level 1 nationally recognized trauma unit --
A Yeah.
Q -- is that a recruiting factor for residents and other physicians?
A Well, yeah, I mean, sure, it helps, obviously. I mean, it's -- and it's, you know, significant. It's beneficial in every aspect.
Q And the demographic area that the University HealthCare Center services as well?
A The demographic area?
Q Yes, if you know.
A It's probably three hours in every direction.
MR. PAFUNDA: Thank you. That's all I have.
THE WITNESS: That's a huge catchment area.
EXAMINATION
BY MR. BEAUMAN:
Q Dr. McGrath, would you agree with me that

Dr. Kearney has exhibited aggressive and humiliating behavior among colleagues and staff?
A I don't know that I'd use those terms.
Q Would you agree with me that you are aware of numerous serious complaints that required management intervention concerning Dr. Kearney?
A So how many is numerous?
Q You know, I don't know. What I'm looking at is really not defined in term of -- are you aware of any serious complaints?
A So I knew of a complaint, again, for whatever reason I sort of find -- I don't have firsthand knowledge of any of these that actually occurred. They seem to come out of different offices. But one, it was a few years ago, and I had heard of an incident that prompted a large review that you're all familiar with. And then Cliff Iler sat down with Dr. Kearney and Dr. Zwischenberger and set out some parameters based on that.
Q Okay. I appreciate that. We've covered several different incidents. I realize you may not know the person's names that were

involved, but can you give us more detail about what you recall?
A I don't.
Q All right. Fair enough. Would you agree with me that Dr. Kearney's attitude toward colleagues is perceived as derogatory?
A I don't -- as derogatory. I'm trying to think of the exact word. I don't know that I would necessarily say he's derogatory to his colleagues. There's probably some people that have perceived his comments as being derogatory. I've not sort of, you know, watched him be, you know, derogatory directly to somebody. He'll make comments that could be perceived that way, perhaps.
Q Okay. Would you agree with me that his attitude impacts student education?
A His attitude impacts student education? Well, I mean, he gets teaching awards, so if that's the attitude you're talking about...
Q Well, let me ask, do you believe that his attitude towards his colleagues negatively impacts student education?
A No.
Q If you will, there is a binder on the table,

Dr. McGrath, in front of you. If you'll turn to page 61.
A Okay.
Q And I can inform you this was a -- this correspondence dated January 7th, 2009, purports to be signed by Dr. Zwischenberger, Colleen Swartz, Dr. Depriest, and yourself, correct?
A Uh-huh (affirmative).
Q That's your signature on this page?
A That is my signature.
Q Would you read the first paragraph to the panel, please?
A "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 intervention. In addition, his attitude toward colleagues is perceived as derogatory and impacts on student education. We have exhausted our local and usual resources and do not believe that inactivity is safe for our patients, Dr. Kearney, or the institution. Dr. Kearney is a respected

colleague and valuable surgeon. We want him to serve out his career at UK HealthCare; however, we believe that without identifiable intervention, Dr. Kearney and UK HealthCare are at risk."
Q Okay. Thank you, Dr. McGrath. You didn't need to read all that.
A Oh.
MR. BEAUMAN: That's fine. Thank you.
EXAMINATION
BY MR. PAFUNDA:
Q Just a second. Would you keep that open, Dr. McGrath?
A Sure.
Q On January 7th, 2009, something happened in Dr. Kearney's life, didn't it?
DR. KEARNEY: January 9th, actually.
A Yes. [redacted]
BY MR. PAFUNDA:
Q [redacted]?
A Yeah.
Q The first phone call he made was to you?
A Yeah.
Q And you two shared a bond?
A Yeah.

Q And still do?
A Right.
PROFESSOR LAWSON: Any other questions, Mr. Pafunda?
MR. PAFUNDA: Yes.
[redacted]
DR. HAMILTON: Yes.
[redacted]
DR. KEARNEY: They were best friends.
PROFESSOR LAWSON: Mr. Pafunda, you had some more questions?
MR. PAFUNDA: No, I have nothing further. Thank you, Dr. McGrath.
PROFESSOR LAWSON: Thank you very much.
(BREAK TAKEN.)
MR. BEAUMAN: The witness list, the amended witness list were supposed to be people who will testify.

MR. PAFUNDA: My understanding, and you correct me if I'm mistaken, is everybody wanted me to whittle down the witness list from 243 to a manageable number, and that's what I've done. If he's not on there and you want to excuse him, that's fine too.

PROFESSOR LAWSON: I think we'll proceed and let him testify.

MR. BEAUMAN: Okay.

PROFESSOR LAWSON: Mr. Lynch, all the witnesses who are testifying before the hearing panel are asked to affirm that they will testify accurately and truthfully. On behalf of the hearing panel, I ask if you will please do that in giving your testimony.

THE WITNESS: I will.

JAMES LYNCH, M.D.,

testified as follows:

EXAMINATION

BY MR. PAFUNDA:

Q You have to state your name for the record,

Dr. Lynch.

A James Lynch, L-Y-N-C-H.

Q All right. Dr. Lynch, we're going to be brief. You are a resident here at the university?

A I'm a chief resident in general surgery at the University of Kentucky.

Q What year are you in?

A Fifth.

Q And you've selected general surgery for what reason or reasons?

A I originally selected it as a path to cardiothoracic, but after working with a lot of the surgeons at UK, I saw the light and decided general surgery is where I could do the most good.

Q And in that regard, to state the obvious, you've been with Dr. Kearney throughout the entire five-year period of time?

A Sure have, yeah.

Q All right. He uses foul language?

A Yes, he does.

Q All right. Do you take offense to it?

A No, not at all.

Q Why not?

A It's the -- in some ways it's the culture of surgery. In some ways it's used as a way to redirect us when things are running afoul. It's always used to bring order to a situation, not to create disorder. When Dr. Kearney starts to cuss, it's not because he's trying to make a show; it's because things are going wrong and things need to be redirected. You can raise your voice; you can cuss. There's lots of ways to bring order to a situation. That's his way. It always has been his way, and it's very effective.

Q You're about to step out into the world to practice where?

A In Morehead, Kentucky.

Q Are you sure?

A Yeah.

Q Okay. Are you going to carry over his techniques to your practice in general surgery?

A Absolutely. I think there's a lot of things that you learn from Dr. Kearney, and like I said, the number one thing is when things are spiraling out of control, there's only so

many ways to redirect people. And like I said, none of them are at times very palatable. You know, if you say, you know, do I have to raise my voice? Sometimes, yes, you have to raise your voice. Do I have to cuss? You don't ever have to cuss. I'm sure there's people that do it without cussing. But sometimes it's a way to bring order into a place where sometimes order is lacking. And it's not just so people can say, "Look at me"; it's because patients can die. Patients can die if things are allowed to progress in disorder. And the one thing that you learn from Dr. Kearney is there's only one guy in charge. There has to be one person in charge, and everybody has to know who that is. That's why you have to be the one to bring order to the situation. So if you ask me, am I going to use the techniques that Dr. Kearney taught me about how to be in charge of the operating room, how to be a good surgeon, and how to bring order to disorder? Absolutely.

Q And when you talk about these situations, and we really haven't touched on this much, but

is time of the essence?
A Absolutely.
Q Explain to us why time is of the essence.
A Most of the time when -- I think when surgeons get upset is because patients aren't doing good. You don't hear people cussing when things are going good. When things aren't going good in the operating room, it's a matter of time before patients suffer. Whether that's not having the proper equipment, not having the proper staff, residents doing things incorrectly, it's a matter of time before that hurts a patient. You know, these patients come in here and entrust their lives to us, and they expect us to move mountains to make them better. And I certainly have never been offended at somebody trying to do right by the patient, no matter if it, you know, if it meant cussing or raising their voice. They're trying to help the patient, and I think that's what everybody understands about an operating room. If you spend time in an operating room, one person is in charge. One person can direct the flow of the operation,

and that has got to be the surgeon.
Q And I take it from your answer that the clock on the wall is ticking while you're in there?
A Absolutely. You know, Dr. Kearney, one thing he teaches you is that nobody stands up and claps at the end of an easy procedure. Everybody expects it to go well. Whether that's getting your tonsils out or putting a PEG tube in, nobody stands up and claps at the end of it and says, "Great job, you're a great doctor." But if something goes wrong, everybody's all over you. So that means you can't let your guard down. Every procedure can potentially kill somebody. So there are no easy procedures. There's no lay-ups. If a PEG goes wrong, people are going to be like, "It was just a PEG." They have no idea how hard it is to make even routine procedures go good. And when things start to go bad, that's when you have to take control. You have to take control. Somebody has to be in charge, no matter how easy the procedure, because things that seem seemingly safe can kill people.
Q To move on to another subject, there was an

e-mail sent out to the residents. Do you know what I'm talking about?
A I do.
Q Would you tell the panel what the e-mail was about and what impact, if any, it had on the residents?
A It was an e-mail that basically said we weren't required to talk to any outside lawyers regarding Dr. Kearney's case, that if we needed protection from the university, that they would offer a lawyer to go with us to talk and that, you know, we could certainly run anything we needed to by the UK legal staff or our higher-ups before being obliged to talk to somebody.
Q And that somebody was me?
A I assume so.
Q And how did you take that? How did you react?
A You know, I didn't like it. I didn't like it. I thought that, you know, we should be able to talk to whoever we wanted. I didn't feel like it was as much written for my protection as to let me know as a resident that they're aware this is what's going on

and that, you know, the university is watching is what I felt like.
MR. PAFUNDA: That's all I have.

EXAMINATION

BY MR. BEAUMAN:
Q Dr. Lynch, I'm Bryan Beauman. You're very loyal to Dr. Kearney, aren't you?
A I am loyal to Dr. Kearney.
Q You feel like he's taught you a lot?
A More than any other surgeon.
Q And you look up to him as a mentor?
A I think we should; I think we all should.
Q You've mentioned earlier that raising voices and cussing brings order into the operating room. What about doing it in a way that is demeaning or humiliating to physicians or staff members?
A I don't feel I've ever been demeaned or humiliated in the operating room, so you'd have to clarify what that means.
Q Maybe you haven't, but do you know of anyone else who has?
A Not personally. I don't find it offensive, you know, if we're -- some things are said in the spirit of the operating room, so just in

a joking manner, and I don't find that offensive. And when it's battle time, when things are going wrong, words are not going to hurt my feelings.

Q Do you believe in the future that if you had a nurse who just scrubbed into one of your procedures, you would greet her by saying, "Hey, bitch"?

A It depends on my relationship with that nurse.

Q What if she had previously told you that she didn't appreciate your cursing and asked that you refrain from that type of behavior around her?

A I'd try, try not to.

Q Would you agree with me it would be inappropriate to tell a nurse that she should wear a colostomy bag over her head because she has shit for brains?

A Again, it depends on my relationship with that nurse.

Q Do you think that comment would be appropriate?

A I've heard that comment a lot.

Q You think that comment is appropriate?

A It depends on, like I said, the situation.

Q So it may be appropriate to say that to a nurse?

A I think so. I think it depends on your relationship with that nurse.

MR. BEAUMAN: That's all I have, Dr. Lynch. Thank you.

EXAMINATION

BY MR. PAFUNDA:

Q Let's talk about a situation. What's a scrub nurse do in the operating room?

A A scrub nurse is there to pass instruments, to ensure sterility.

Q Is it an important job?

A Very.

Q Why is it very important?

A Because they control the flow of the operation. How fast you get the instruments dictates how fast you can operate. Them having knowledge of the instruments dictates how well a case is going to go.

Q And so if a scrub nurse goes down and the nurse who could step in and help and replace that scrub nurse is on a computer shopping, would you yell at that nurse --

A Absolutely.

Q -- because she didn't step in?

A Absolutely.

Q Because she put patient care at risk?

A Because, again, you're in a -- that's the disorder I talk about. That's the disorder of the operating room that happens sometimes. You've got a nurse down, or you've got a scrub nurse down. You have somebody who can help you. You have to get them to help you, and sometime you can ask nicely and that doesn't work. You still have a patient there. It doesn't -- there's no time to go talk to their supervisor. There's no time to file a grievance. You have to get it done. You can't -- the patient's just not sleeping. They're under anesthesia. And so, yeah, I think sometimes raised voices are necessary.

MR. PAFUNDA: Thank you, Dr. Lynch.

EXAMINATION

BY DR. HANSEN:

Q I'm sorry. You said that you've heard this comment a lot about a colostomy bag --

PROFESSOR LAWSON: I need for you to speak up because they'll not get you

on this record over here.

DR. HANSEN: Okay.

Q You just said you've heard that and this phrase about a colostomy bag and shit for brains or whatever are common. Could you just expand on that a little bit more for me?

A I think that --

Q Because I've never heard it and I've heard lots of bad things.

A I've heard that from numerous surgeons in the OR. It's kind of an inside surgical joke. You know, I think if you talk to the average person, they're not going to know what you do with a colostomy bag anyway. It's just one of those things. It's immature, but it's kind of witty. It's the culture. I think that's the culture.

Q So it is a culture that is pervasive, would I be right to say, in the OR or just among surgeons?

A It depends, depends on where you're at. It's certainly different in every operating room, but it's certainly a culture that I'm used to. It's a culture that we have here at UK.

Q It sort of sounds berating, "shit for

brains," right?
A Yeah.
Q So is it something that's typically said to folks that are lower than you? Because there's a hierarchy, right?
A No.
Q Or is that said to each other?
A Absolutely said to each other. I'd say 99 percent of this is between the attending surgeon and the resident surgeon, and it's like a tennis match. It's a volley back and forth.

DR. HANSEN: Okay.

PROFESSOR LAWSON: Any other questions?

EXAMINATION

BY DR. HAMILTON:

Q How many chief residents are there in surgery?
A Six.
Q So how many PGY-5 residents?
A Six.
Q Okay. So all --
A That is your chief year; your fifth year is your chief year.

DR. HAMILTON: Okay.

PROFESSOR LAWSON: Anything else? Thank you very much.

THE WITNESS: Yes, sir.

DR. KEARNEY: Send Lisa in, will you?

THE WITNESS: Yeah.

(OFF THE RECORD.)

PROFESSOR LAWSON: Ms. Fryman, all witnesses testifying before the hearing panel are asked to affirm that they will testify accurately and truthfully on behalf of hearing panel. I ask if you will commit to do that in giving your testimony.

THE WITNESS: Yes.

PROFESSOR LAWSON: Proceed.

MR. PAFUNDA: Thank you.

LISA FRYMAN

testified as follows:

EXAMINATION

BY MR. PAFUNDA:

Q Would you state your name for the record, please?
A Lisa Fryman.
Q All right. And you do what here at the University of Kentucky HealthCare?

A I'm the nursing director for trauma and surgical services.
Q And what do your duties include?
A I have all of the inpatient units. I'm the nursing director for all the inpatient units that house the trauma and surgical patients, and my responsibilities are operations, nursing operations for our service line. And it has a continuum of care, ICU and acute care and progressive care. I'm also responsible for the trauma program, and dialysis unit reports to me as well.
Q What aren't you responsible for?
A Nurse sciences.
Q All right. And how long have you been in that position?
A Three years in this position.
Q And prior to that time?
A I was the trauma program manager, and I took that position in 2005.
Q And prior to your trauma manager position in 2005?
A I was a staff nurse in the emergency department, and prior to that I was a staff nurse in Nurse Surgery ICU.

Q And you've known Dr. Kearney for how long?
A In a professional manner since 1994 when I started as a bedside nurse in Nurse Surgery ICU.
Q And in your opinion, is he professional?
A Yes.
Q Does he have a mouth?
A Yes.
Q And when you worked with him, did you take offense to his language?
A No.
Q Would you tell the panel why not?
A Dr. Kearney, his intent is always for the utmost protection of patients and their outcome, and his actions are always driven as patient-centered and the best care for the patient with anybody that is directly caring for the patient at the bedside: resident, physician, ancillary staff.
Q Are there nurses that want to work with Dr. Kearney?
A Yes.
Q Tell the panel why.
A Because Dr. Kearney is a very honest physician. He cares deeply about his

patients and the care that they get. It doesn't matter what is going on or what the patients -- what's happening with the patient; he's always focused on the best outcome for the patient. And he cares about the patient and he cares about educating the staff to be the best caregivers that they can give. He has -- he teaches at the bedside. He teaches informally in the units, and he's just -- and it's always how to better your professional -- your own professional development.

Q And have you watched as he's built the trauma center into a Level 1 nationally-ranked trauma center?

A Yes.

Q And you say that; tell the panel what you've seen.

A Dr. Kearney has very -- a very strong commitment to the development of our trauma center. I started the job in 2005, and when I looked back, you know, to see when we started, he was here, I think, in late 1988, and he developed -- he was one of the original developers and moved the University

of Kentucky from an academic medical center -- the regional medical center to a Level 1 trauma center verified by the American College of Surgeons, and that is very difficult to do. It's very rigorous, and he's held all of the standards that the American College of Surgeons set forth to be a premier Level 1 trauma center and maintained it and held everybody to the standard to maintain that Level 1 trauma center. And I think we've been verified since 1990.

Q And he's brought that recognition to the university?

A Uh-huh (affirmative).

MR. PAFUNDA: That's all I have.

PROFESSOR LAWSON: Mr. Beauman.

EXAMINATION

BY MR. BEAUMAN:

Q Ms. Fryman you mention there are nurse who want to work with Dr. Kearney. There are also nurses who don't want to work under him, aren't there?

A Not that I'm not aware of.

Q Do you know [redacted]?

A Who?

Q [redacted].

A No, I don't.

Q How about [redacted]?

A No.

Q [redacted]?

A No.

Q [redacted]?

A No.

Q [redacted]?

A No.

Q [redacted]?

A No.

Q You don't know any of those nurses?

A No.

Q So you're unaware of the complaints that they made against Dr. Kearney, then, I assume?

A Yes, I am not aware of them.

Q You're not aware whether they've reported that they do not want to work under Dr. Kearney, are you?

A Correct, I am not aware.

Q Are you aware of any nurse at UK who is intimidated by Dr. Kearney?

A No.

Q No one?

A No.

MR. BEAUMAN: All right. Thank you. That's all I have.

(BREAK TAKEN.)

PROFESSOR LAWSON: All the witnesses who are testifying before the hearing panel are asked to affirm that they will testify accurately and truthfully. On behalf of the hearing panel, I ask if you'll commit to do that in giving your testimony.

THE WITNESS: Yes.

PROFESSOR LAWSON: Okay.

ANTHONY BOTTIGGI, M.D.,

testified as follows:

EXAMINATION

BY MR. PAFUNDA:

Q Would you state your name for the record, please.

A Anthony Bottiggi, B-O-T-T-I-G-G-I.

Q Where are you from?

A I'm here in Lexington, but originally upstate New York.

Q Just found out in the hallway we're, like, from the same neighborhood?
A Pretty close, 20 miles.
Q What brought you to Kentucky?
A Well, my father is a pediatrician and did his residency here, so I grew up here until I was ten and then moved to upstate New York. I was wanting warmer weather than Buffalo, where I went to med school.
Q And came back?
A Yeah.
Q And what do you do now, here at the university?
A I'm on faculty with the Division of General Surgery and the Section of Trauma and Critical Care, and I'm also at the VA Hospital.
Q And did you matriculate through your residency here with Dr. Kearney?
A Yeah, residency and fellowship.
Q All right. And would you tell the members of the panel your impressions of his professionalism?
A I mean, Dr. Kearney, I'll put it this way: If I was sick and dying, who would I want to

take care of me? It would be Dr. Kearney.
Q That says it all.
A If one of my family members was sick, who would I want taking care of them? Dr. Kearney.
Q And what about his teaching ability?
A Well, having trained under him, I think my class gave him a teaching award, if I'm not mistaken, at our chief resident roast. I know he's received multiple awards over the years from both med students and residents.
Q And why does he stand out as a teacher?
A Because he makes you learn, you know. I mean, you learn under him. He teaches you to be a physician, and the one thing that he teaches probably more than anybody else is that it's your personal responsibility to take care of the patients and not shirk it off on somebody else. I mean, anybody can teach you palliative physiology and this and that, but at the end of the day, if there's anybody who's truly about patient care, it's Dr. Kearney.
Q In that regard, do other surgeons use profane language in the operating room?

A As surgeons, it's not uncommon, no.
Q And has already been pointed out on multiple occasions here, it's part of the culture?
A It's part of the culture. Not just surgeons; I've seen ancillary staff do it as well.

MR. PAFUNDA: That's all.
MR. BEAUMAN: I have nothing.
PROFESSOR LAWSON: Okay. You've got one more?
MR. PAFUNDA: One more, Dr. Andrew Barnard.
(OFF THE RECORD.)
PROFESSOR LAWSON: Dr. Barnard, all the witnesses who are testifying today before the hearing panel are asked to affirm that they will testify accurately and truthfully. On behalf of the hearing panel, I ask if you will commit to doing that in giving your testimony.
THE WITNESS: Yes, sir.
PROFESSOR LAWSON: Mr. Pafunda.

DR. ANDREW BARNARD, M.D.,
testified as follows:

EXAMINATION

BY MR. PAFUNDA:
Q Good afternoon -- or good evening. Dr. Barnard, would you state your full name for the record?
A Andrew Coleman Bernard.
Q Where are you from originally?
A From Frankfort.
Q All right. And I take it you did your residency here?
A Yes, sir.
Q And so you're Dr. Kearney's partner, right?
A Yes, sir.
Q And as a resident, Dr. Kearney walked you through your residency?
A Yes, sir. He was here when I was a medical student too.
Q And your present position here?
A I'm currently the Trauma Medical Director.
Q What does that entail?
A I'm responsible for the clinical operations of the trauma program, the quality and the safety and the clinical outcomes.
Q Do you sit in Dr. Kearney's chair, endowed chair, now?
A Yes, sir, I'm the Paul Kearney chair.

Q When did you sit in that endowed chair?
A It's been about two and a half years now.
Q How did that occur?
A The chair was endowed by a benefactor, and I was chosen by the department to sit in the chair.
Q And how does that selection process go?
A It's related to academic rank, and it's also related to expertise and career path in research. It's a chair that's intended to allow faculty to be more active in research, alongside being clinically active.
Q And so you, as the sitting endowed chair, Paul Kearney chair, your aim is to do what?
A Deliver excellent care and to do cutting edge research and teach.
Q And carry out the traditions of that particular named chair?
A Certainly his name carries a great deal of weight to me.
Q All right. And would you explain to the panel, please. It carries a great deal of weight; explain to the panel in what way.
A Well, Paul is my mentor. I met him in 1990 when I was a medical student -- when I was an

undergrad student, actually, before I started medical school. And he's been my mentor, you know, really all the way through. Initially a mentor is a very senior person, and then I've had the privilege to grow in my career path to the point that I was more alongside him as a clinical partner, but he'll always be, honestly, much greater than I, always be more senior. But that relationship is deep and strong.
Q So I take it, given your selection to the chair, that you want to carry that tradition on?
A Yes, sir. I will never really accomplish it, but I'll strive to.
Q Why would you say that? Because you look so young and you must be so accomplished.
A I hope I have a few years left, but I'll never -- never be able to achieve what he's achieved. So much has been built.
Q Of course, if his privileges are suspended permanently, the chair won't there be anymore, will it?
A The chair will be there. The chair has been endowed in perpetuity from what I understand.

The name may have a little bit different significance, not to me, but it will always be there in perpetuity.
Q Let me ask you this. Since he's been suspended from practice, has patient care suffered? And I don't mean that in a lawyer "I'm advertising for cases" kind of TV thing, but I mean, has it suffered?
A I don't have any way to measure that, but Paul, as the senior member of the group, has always been the resource that even the now more senior guys like myself and the other more senior guys look to for guidance. So certainly there have been cases while he's been gone that all of us would have wanted to talk to him about but haven't been able to. Certainly the partners have suffered.
Q Well, let me ask you this. When you say talk to him about, is he the kind of man that you can call on the phone and say, "Get down to the hospital," and he'll come down?
A Yes.
Q Just to help out?
A Yes.
Q Has he done that?

A Always.
Q And I heard earlier today from one of the residents that they've actually called him to ask him questions on procedures. Have you had occasion since he's been suspended to call him and ask about procedures or any of your other partners?
A Have I or other partners called him?
Q Yes.
A Yes. I don't recall a particular case where I've called him during the time he's been out. I wasn't sure what all sorts of clinical interactions it was okay to have so...
Q But whatever the clinical interactions were, it was patient care first?
A Yes.
Q So you called him?
A Yes.
Q All right. Would you agree that there's -- and I hate to use it this way -- a culture of profane language throughout the surgery OR?
A The OR is special place. There's certainly things that -- there are certain things that are said in the OR that are different than

any other clinical arena. For right or wrong, that certainly is the culture.

Q And when you say that the OR is a special place, we've heard testimony about it throughout this day, but from your vantage point, describe to us from your viewpoint, why is it a special place?

A Patients live and die in a matter of seconds or minutes in the operating room, and that's stressful. It's also a place where, here, we train. So we train young people to become capable, competent surgeons that can -- that can do what we do when they're independent. So it's stressful delivering the care, and it's stressful maintaining the rigor that we need to, to develop future surgeons.

Q How do you cope with that stress?

A It's not easy.

Q No, I'm genuinely asking.

A It gets harder as you get older, and I cope less well now I than used to; at least it's harder on me physically. But you share with colleagues. You derive pleasure from the trainees, and you derive support from your coworkers and staff, and then you try to

decompress. Dr. Kearney always exercised as an outlet, and that's something I've taken from him, and that's an important outlet for me too. Physical strength is more and more important as you get older as a trauma surgeon.

Q You don't know how true that is even if you're not a trauma surgeon. Dr. Kearney is a 61-year-old. He's still able to cut it, isn't he?

A Yes.

(SOTTO VOCE DISCUSSION.)

MR. PAFUNDA: You've got to give me a minute. We're having a debate, a serious debate.

DR. HAMILTON: Is it okay if we ask questions in the interim?

PROFESSOR LAWSON: Yes.

MR. PAFUNDA: Yes, go ahead.

EXAMINATION

BY DR. HAMILTON:

Q Andrew, I noticed that you recused yourself from the activities of the Medical Staff Executive Committee, as it's called here. Why was that?

A I felt like the structure of the Medical Staff was adequate to adjudicate whatever decision had to be made --

Q Uh-huh (affirmative).

A -- independent of me. I felt like there were enough other votes, and I feel very deeply and personal about Paul.

Q Uh-huh (affirmative).

A And wasn't sure that I would -- that I would be able to -- I'm not -- I think I'm so close, I wasn't sure I would be able to deliberate in the way that I think a Medical Staff Committee Member -- Medical Staff Executive Committee member should, just too close. I wasn't a generic member of the Medical Staff Committee.

Q So would it be fair to say that you recused yourself because you did not feel that you could be unbiased in evaluating what was being brought before the Medical Staff Executive Committee?

A I think -- I think more than -- I think I probably could have adjudicated when it came down to a vote, but in the course of dialogue, it would be hard for me -- it would

be hard for me to withhold everything in my head in terms of sharing with the group. Maybe that would have been a reason not to recuse myself, but I felt like I have such a deep experience that I could potently bias the group in the other way because my experiences are different.

Q And how do you feel about that decision now, based on where this has progressed?

A I'm not sure. I'll always deliberate that. I'm never going to let that go. Perhaps I was in a position to lobby, justifiably, and as I would feel comfortable doing, to provide deeper context, so I'm not sure if I had to do it over. There's a big infrastructure associated with it, you know. It's a big process. It's a big system, and maybe that was a copout.

DR. HAMILTON: Thanks for your honesty.

DR. HANSEN: How long has the --

PROFESSOR LAWSON: Speak louder, please.

EXAMINATION

BY DR. HANSEN:

Q How long has the endowed chair been -- are you the first Paul Kearney endowed chair?

A Yes, ma'am. It's only been --
DR. KEARNEY: I sat in the chair, my own chair, so it was.
THE WITNESS: Yeah, Paul was the first.
DR. HANSEN: For several years?
DR. KEARNEY: '08 to whenever I stepped down, when I stepped down of my own accord after 20 years of doing it because I was gassed and I didn't have any new ideas. You've got to let younger blood -- you burn out. So Andrew took over the chair when I resigned in 2012, I think. Beginning of 2012 is when I resigned as the chair -- as the chief, excuse me, and chair.
BY DR. HANSEN:
Q Context: You're head of the -- medical director of the service line of trauma?
A Yes, ma'am.
Q So you deal a lot with nurses, and there's a hierarchy always with things. In that context, are there many people or many who you might consider good nurses that don't want to work with Dr. Kearney?

A No.
Q Okay. Because you are the leader of that, I'm sure you get a lot of complaints of everybody, of lots of things, right, patients, you name it?
A Patient, people, and systems, I hear the complaints.
Q Do you get many on Dr. Kearney?
A No.
PROFESSOR LAWSON: Mr. Pafunda, do you have any more questions?
MR. PAFUNDA: Yes, but I was going to wait on Mr. Beauman. Do you?
MR. BEAUMAN: I'll wait till you're finished.
MR. PAFUNDA: Thank you.
BY MR. PAFUNDA:
Q You don't have to second-guess yourself on the recusal. I mean, you know Paul Kearney, right? I'll take it even one step further. Maybe this -- did you know on April 14th, when Dr. Kearney blew the whistle on Dr. Michael Karpf, that Dr. Karpf in that meeting threatened to fire him, Paul?
A No. On that date?

Q On that date, April 14th, last year?
A Did I know on that date that that occurred?
Q Yeah.
A No, sir.
Q Did you know later?
A I heard that later.
Q All right.
A I had heard about an interaction that Paul had. I heard about that meeting, but the specific context of that meeting, specific details, I don't have knowledge of, no.
Q All right. Dr. Boulanger, you know him?
A Yes, sir.
Q When you were a resident, did you have an interaction with Dr. Boulanger where he physically assaulted you?
A No. He's never physically assaulted me.
MR. PAFUNDA: That's all.
MR. BEAUMAN: I don't have any questions.
PROFESSOR LAWSON: Thank you.
MR. SALSBUREY: Thank you, Dr. Barnard.
DR. KEARNEY: Thanks, Andrew.
PROFESSOR LAWSON: Now, these two lawyers can't be here tomorrow after

what?
MR. BEAUMAN: I need to leave about 3:00, 3:15.
PROFESSOR LAWSON: Could he stay?
MR. SALSBUREY: I can stay till about 4:00.
DR. KEARNEY: We should be done; it just depends on the flow.
(OFF THE RECORD AT 4:43 P.M.)

STATE OF KENTUCKY)

COUNTY OF FAYETTE)

I, ROBYN RICHARDSON, CCR, the undersigned Notary Public in and for the State of Kentucky at Large, certify that the facts stated in the caption hereto are true; that at the time and place stated in the caption said hearing was taken down in stenotype by me and later reduced to computer transcription under my direction, and the foregoing is a true record of said hearing.

My Commission Expires: January 17, 2016.

IN TESTIMONY WHEREOF, I have hereunto set my hand and seal of office on this the 8th day of June, 2015.

ROBYN RICHARDSON, CERTIFIED
COURT REPORTER, NOTARY PUBLIC,
STATE AT LARGE, KENTUCKY
CERTIFICATE ID: 249421