RENDERED: JUNE 25, 2026
TO BE PUBLISHED

# Supreme Court of Kentucky

2025-SC-0042-DG

JOHN MITCHELL FARMER, M.D. — APPELLANT

V.

ON APPEAL FROM COURT OF APPEALS
NO. 2023-CA-0809
JEFFERSON CIRCUIT COURT NO. 20-CI-006143

BAPTIST HEALTH MEDICAL GROUP, INC., AND BAPTIST HEALTH MADISONVILLE, INC. — APPELLEES

**OPINION OF THE COURT BY JUSTICE CONLEY**

**REVERSING**

This case is before the Court upon discretionary review after the Court of Appeals reversed a $3.5 million jury verdict in favor of the Appellant, Dr. John M. Farmer against the Appellees, whom we collectively refer to as Baptist Health. There are multiple issues presented by this appeal, including whether Dr. Farmer has a valid cause of action for tortious interference with prospective business relations, and whether the trial court made evidentiary errors in excluding evidence arising from Dr. Farmer's involvement with the Kentucky Physicians Health Foundation (KPHF). Upon review, we conclude Dr. Farmer has a valid cause of action and there were no reversible errors at trial. The Court of Appeals is reversed, and the judgment and award of the trial court are reinstated.

## I. Facts and Procedural Posture

Typically, our opinions begin with a recitation of the facts and then proceed to discuss principles of law. The Court of Appeals' opinion in this case, however, is so discordant with and contradictory to the facts as the jury believed them to be that it is necessary to remind the reader that

> [u]pon review of the evidence supporting a judgment entered upon a jury verdict, the role of an appellate court is limited to determining whether the trial court erred in failing to grant the motion for directed verdict. *All evidence which favors the prevailing party must be taken as true* and the reviewing court is not at liberty to determine credibility or the weight which should be given to the evidence, these being functions reserved to the trier of fact. The prevailing party is entitled to all reasonable inferences which may be drawn from the evidence.

*Louisville & Jefferson Cnty. Metro. Sewer Dist. v. T+C Contracting, Inc.*, 570 S.W.3d 551, 576 (Ky. 2018) (emphasis added). As to how the Court of Appeals came to disregard this standard, it will be discussed below. With these preliminaries out of the way, we can now proceed to the facts as the jury found them to be, but we will, for fairness' sake, note those issues in which Baptist Health raised an issue of disputed fact for the jury to resolve.

Dr. Farmer graduated medical school in 2017. He was hired that same year to work at Baptist Health Madisonville to do his residency in the Family Medicine practice. For two years, he worked without significant incident. On November 4, 2019, around 4:15 pm, Dr. Farmer was treating a minor patient who was prescribed Adderall to manage her attention deficit disorder. Dr. Farmer determined that the dosage of the child's prescription should be

lowered. Afterward, the child's mother asked to see the Practice Manager, Stephanie Crick.

Crick is a Registered Nurse of twenty-three years' experience in nursing at the time of trial in 2024. She was an RN at the time of the November 4 incident. As Practice Manager, she handled the day-to-day office affairs of the Family Medicine practice at Baptist Health. As such, she frequently interacted with Dr. Farmer and generally testified to her opinion that Dr. Farmer is a good doctor. She testified the complaining mother informed her that Dr. Farmer was perhaps "on something," that he was rubbing his nose a lot, and shifting his weight from side to side. Crick testified she did not credit the mother's complaint as anything to be worried about, as the behavior described by her was normal for Dr. Farmer. Dr. Farmer has been diagnosed and treated for attention deficit hyperactivity disorder (ADHD) since 2005. Crick testified the behavior described in the complaint is, contrary to the mother's belief, consistent with ADHD symptoms and with Dr. Farmer's typical behavior. Since Crick was not in charge of the physicians in the office, she believed she had to report the complaint to Dr. Diana Nims, Residency Program Director for Baptist Health at the time.

Dr. Diana Nims' relationship with Dr. Farmer was a subject of dispute at trial. Dr. Farmer testified to his belief that Dr. Nims had a romantic interest in him, which he did not reciprocate towards her. Dr. Nims denied this, although Crick did testify Dr. Nims once told her Dr. Farmer had a crush on her, Dr. Nims, that is. The relevance of this fact is somewhat suspect as Dr. Farmer's

First Amended Complaint does not allege Dr. Nims had a romantic interest in him nor that her conduct on November 4 stemmed from her unrequited desire for him. Regardless, the jury award in favor of Dr. Farmer compels us to accept his testimony as true.

Dr. Nims spoke with Dr. Hargrove and Dr. Hatler about Dr. Farmer on November 4. Dr. Hargrove has forty years' experience in emergency and family medicine and testified to treating hundreds of patients for drug and alcohol abuse. He affirmed to Dr. Nims that he was "100% sure" Dr. Farmer was not impaired on November 4. Dr. Hatler, who was supervising Dr. Farmer that day and was in the room with Dr. Farmer for part of the time while he treated the mother and child that precipitated the complaint. Dr. Hatler informed Dr. Nims he noticed nothing unusual about Dr. Farmer on November 4. He testified if he had suspected any impairment, he would have sent Dr. Farmer for testing. Both doctors told Dr. Nims in no uncertain terms that they did not believe Dr. Farmer was impaired.

At approximately 5:00 pm, Dr. Nims met with Dr. Wayne Lipson, the Chief Medical Officer of Baptist Health at the time, Dr. Armstrong, President of Baptist Health Madisonville's Medical Staff at the time, Robert Ramey, President of the hospital at the time, and Rhonda Florida, head of the Medical Staff office, whom we will collectively refer to as "the leadership." Dr. Nims told the leadership that Dr. Farmer was the subject of a complaint which raised a concern about an impairment. She told the leadership Dr. Farmer had a "history of alcohol abuse," which Dr. Lipson confirmed was solely based on a

DUI conviction Dr. Farmer received in 2013 during medical school, and which Baptist Health was informed about when it hired him. Dr. Nims told the leadership Dr. Farmer had suicidal ideation a year prior. She told the leadership that Dr. Farmer was receiving treatment from a psychiatrist.

What Dr. Nims did *not* tell the leadership was the "suicidal ideation" episode from a year prior had resulted in Dr. Farmer being sent to a Dr. Laird, a mental health professional, who concluded Dr. Farmer's statement was a joke taken out of context. Dr. Laird did not conclude Dr. Farmer suffered from suicidal ideation and did not recommend any further treatment whatsoever. Dr. Nims did *not* tell the leadership that Dr. Farmer's treatment with a psychiatrist was solely related to his ADHD diagnosis, although the leadership was aware of that diagnosis according to Dr. Lipson. She did *not* tell the leadership that she had interacted with Dr. Farmer that day and her own opinion from that interaction was that he was "not acutely impaired." Dr. Nims did *not* tell the leadership about Drs. Hargrove's and Hatler's opinions that Dr. Farmer was not impaired in any way that day.

Regarding this last point, Dr. Lipson testified to being unaware of the opinions of Drs. Hargrove and Hatler on November 4. Nonetheless, he repeatedly testified those opinions were irrelevant.[1] According to Dr. Lipson, the issue was not about alcohol in particular but about impairment.

[1] Dr. Nims testified she did inform the leadership of these conversations. None of the other leadership corroborated this statement at trial. Dr. Lipson adamantly denied it. The memorandum of the November 4 meeting written by Rhonda Florida does not mention the opinions of Dr. Hargrove or Dr. Hatler. Dr. Nims testified this memorandum was circulated to her and she had an opportunity to recommend any

> "[N]o one ever said anything about alcohol. That wasn't the question of alcohol, of somebody having alcohol. It could have been emotional, could have been drug-related, could have been narcotic, could have been psychiatric, could have been physical. I mean, these are all types of impairments. So, no one ever, no one ever thought, we weren't sitting there thinking he was drunk."

Dr. Lipson, however, reversed course when confronted with whether the decision was based on a 2013 DUI, and an exaggerated and mischaracterized report of suicidal ideation. "We weren't concerned about what was in the past. We were concerned at what we were dealing with at that time, at that day and time." The events of the past were, to use his phrase, merely "data points" which informed the analysis of whether Dr. Farmer was safe to practice medicine.

When confronted with why the leadership did not consider whether the reported behavior was consistent with typical behavior of Dr. Farmer; did not consider whether the reported behavior was consistent with a person suffering from ADHD; or why the opinions of two other doctors as to the lack of impairment were irrelevant, Dr. Lipson would then revert back to the contention that the leadership was focused on "a concern brought forth regarding Dr. Farmer." This "concern" was identified by Dr. Lipson as "the concern the patient's mother had[,]" and that the leadership were focused on "evaluat[ing] what had taken place."

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amendments and did not do so. She admitted the opinions of Dr. Hargrove and Dr. Hatler would have been important information to include in the memorandum had those opinions been discussed. Regardless, this is, at worst, an issue of fact for the jury, and we must accept, consistent with its verdict, the facts supporting Dr. Farmer's claims as true.

Suffice it to say, the leadership did make two decisions of consequence that evening. First, they decided not to have Dr. Farmer tested for drugs and alcohol at Baptist Health. Second, they decided to prohibit Dr. Farmer from seeing patients unless he went to the KPHF for testing and treatment. As to the first decision, Dr. Lipson testified foregoing drug and alcohol testing was because it was not in the best interest of Dr. Farmer. When informed the next morning that he could not see patients, Dr. Farmer disagreed with the leadership's assessment of his best interest, and did insist on being tested at Baptist Health which Dr. Lipson refused to allow.

The failure to perform a drug or alcohol test on site forms the basis for Dr. Farmer's breach of contract claim.[2] Baptist Health had a "Fitness for Duty & Drug Testing Policy" applicable "for any employee." The procedure mandated by this policy under the heading "General" requires the Department Manager upon a report of impairment to 1) investigate the situation; 2) interview the employee and initiate a "Fitness for Duty" Evaluation; and 3) document the actions taken. Under the more specific heading of "Suspicion of Being under the Influence of Substances (Alcohol or Drugs)" the policy requires the manager, upon "reasonable suspicion" to remove the employee from the immediate work area to a private room; then escort the employee to Employee Health, the Emergency Department, or any other appropriate medical office; "obtain the employee's consent for the test and ensure appropriate

[2] Dr. Farmer had signed a "Family Practice Resident Agreement" renewed annually that incorporated "Baptist health Madisonville policies, procedures and medical staff rules and regulations as such pertain to Residents."

documentation is completed;" and ensure the "specimen will be collected by a healthcare professional per chain of custody guidelines[.]" Baptist Health argues this policy is not applicable to Dr. Farmer as he was not an employee but a physician.

Assuming *arguendo* that is true, Baptist Health had a "Medical Staff/Allied Health Practitioner Health Policy." This policy was the only one discussed at the November 4 leadership meeting. The policy requires, under the heading "Investigation and Report of Findings," that if, upon receiving a report of impairment, the Hospital President or President of the Medical Staff believes there is enough information to warrant an investigation, that an investigation will take place. The policy allows Baptist Health to designate who will conduct the investigation, including outside consultants. Secondly, the policy allows the investigation to "be conducted by whatever means deemed appropriate by the investigator(s) and should include a meeting with the affected physician." Third, the policy requires that "[u]pon receipt of the investigation report the Hospital President, acting in consultation with the President of the Medical Staff, will determine whether sufficient evidence of impairment exists."

Dr. Nims testified she was not responsible for conducting an investigation and did not have any obligation to discuss the report with Dr. Farmer or to interview any of his colleagues to substantiate the report prior to informing the leadership. Dr. Lipson testified multiple times, "[t]here was not an investigation. There was a concern brought forth regarding Dr. Farmer." The

following morning, November 5, 2019, a meeting took place between Dr. Farmer, Dr. Lipson, and Dr. Nims. Dr. Farmer was presented with a *fait accompli* in which he was told he was prohibited from treating patients and would have to report to the KPHF and comply with whatever it recommended before being allowed to treat patients again. Dr. Lipson testified Dr. Farmer could have refused to go to KPHF, therefore, his choice was "voluntary." He testified that if Dr. Farmer had refused to go to KPHF then a meeting of the Executive Committee would have occurred, and appropriate action would have been determined. He testified he did not inform Dr. Farmer of this secondary course of action prior to Dr. Farmer's "voluntary" acquiescence to report to the KPHF.

Related to this, Dr. Lipson repeatedly testified he never made a referral to KPHF regarding Dr. Farmer. He testified his initial emails to the KPHF were merely seeking consultation and Dr. Farmer was not named. It was only after the November 5 meeting when Dr. Farmer "agreed" to report to the KPHF, that the KPHF was then contacted by phone and informed about Dr. Farmer explicitly. This testimony, however, is belied by the email Dr. Lipson sent the Kentucky Board of Medical Licensure on November 15, 2019, in which he stated: "Based on the anonymous complaint, Dr. Farmer was referred to the Kentucky Physicians Health Foundation ("KPHF") by myself and Dr. Nims." The contradictory evidence between Dr. Lipson's testimony at trial and his statements in the email only eleven days after November 4 makes this an issue

of fact for the jury to determine, and we are compelled to view the evidence in a light most favorable to Dr. Farmer according to its verdict.

After Dr. Farmer reported to the KPHF, he was sent to a third-party testing facility. The results of this test, identified as a PEth test, were not disclosed at trial by court order.[3] The only mention of the results is an email from Dr. Greg Jones, the Medical Director of the KPHF, stating, "The alcohol metabolic marker is very high and not at all consistent with the history he provided, it's a blood test." The record makes clear that a PEth test is a blood test for alcohol markers and can generally determine whether alcohol has been ingested in the last two to three weeks. PEth tests are, however, uncommon in the legal literature. There are several cases mentioning the test in various jurisdictions but none describing it in any detail. The one legal resource we could find describes the PEth test thusly: "All that can be learned from a positive PEth test is there was heavy drinking sometime during the three-week period, but it will not show whether it was a binge weekend or daily heavy drinking." Miles Mason Sr., *Alcoholism & Family Law Step-by-Step Guide to Warning Signs, Testing and Monitoring*, Tenn. B.J., July/August 2022, at 20, 25. Binge drinking is defined as five or more drinks in one sitting. *Id.*

Thus, the PEth test cannot tell whether Dr. Farmer was in fact impaired on November 4, 2019. At this point in our recitation, it is necessary to detail that there is no evidence in the record whatsoever that Dr. Farmer was ever

[3] The result of the PEth test is, however, in the record as part of Dr. Farmer's motion in limine filed on April 6, 2023.

impaired by drugs or alcohol while at work, or that his alcohol consumption, to the extent it exists, ever interfered with his ability to practice medicine.

After the KPHF received these test results, Dr. Farmer was sent to a third-party treatment center, called MARR Addiction Treatment Center. MARR produced a report, which the trial court did not allow Baptist Health to discover from the KPHF, diagnosing Dr. Farmer with Alcohol Use Disorder (AUD)-Mild. A copy of the DSM-5's standards for this diagnosis is included in the record. Therein it is explained that AUD-Mild is the lowest degree of AUD and is warranted when a person reports experiencing two symptoms at least **ONCE** in the past year.[4]

Despite being aware of the MARR Report, Baptist Health never subpoenaed the MARR Addiction Treatment Center. Instead, the MARR Report was obtained by Baptist Health when the trial court, on March 24, 2023, ruled Dr. Farmer had inadvertently disclosed the MARR Report to Baptist Health,

[4] Those symptoms are: 1) drank more, or for longer, than originally intended; 2) more than once wanted to cut down or stop drinking, or tried, but could not; 3) "spent a lot of time drinking? Or being sick or getting over other aftereffects?"; 4) wanted a drink so badly he couldn't think of anything else; 5) drinking, or being sick from drinking, "often interfered" with taking care of home, family, job, or schooling; 6) continued to drink even though it was causing trouble with family or friends; 7) given up or cut back on activities that are important or interesting to him in order to drink; 8) more than once gotten into situations while drinking that increased changes of getting hurt (including driving, swimming, using machinery, walking in dangerous areas, or having unsafe sex); 9) continued to drink even though it was making you feel depressed or anxious or adding to a health problem, or after having had a memory blackout; 10) had to drink much more than you once did to get the effect you want or found that usual numbers of drinks had much less effect than before; 11) and finally, found that when effects of alcohol were wearing off, experienced withdrawal symptoms such as trouble sleeping, shakes, nausea, sweating, etc., or sensed things that were not there.

who apparently shredded the document, and, therefore, granted Baptist Health's motion to compel the MARR Report. Because Baptist Health had the MARR Report in its possession prior to trial it presumably would have been capable of identifying which person(s) at MARR could have been called to testify about it. Baptist Health did not subpoena any such persons or list any such persons on its witness list for trial. The trial court made clear in its March 24 order that its ruling was not regarding admissibility.

On April 13, 2023, the trial court granted Dr. Farmer's motion in limine regarding the MARR Report except to the stipulation proffered by Dr. Farmer (but not agreed to by Baptist Health) which was read to the jury at trial: one, the KPHF required Dr. Farmer to attend a 96-hour program at MARR; two, MARR assigned a diagnosis of AUD-Mild; three, MARR informed the KBML of this diagnosis; and four, Dr. Farmer disputes the diagnosis.[5] Critical to a proper understanding of this issue is Baptist Health did not ask the trial court to admit the Report in its entirety but only wanted its existence, its ultimate diagnosis, and that this diagnosis was shared with the KBML prior to any of its decision-making regarding Dr. Farmer, be admitted; which is exactly what the trial court ruled and what Dr. Farmer's stipulations accomplished. Baptist Health cross-examined Dr. Farmer about the MARR Report and his dispute about its diagnosis.

[5] The trial court also ordered the "evidence that PEth tests were administered as ordered by the KPHF and that the results were utilized as the basis for KPHF's decisions" would be allowed in but not the test results themselves. Dr. Jones was listed as witness by Baptist Health prior to trial but it never called him to testify.

To return to our narrative, on November 15, 2019, Dr. Lipson reported Dr. Farmer to the KBML based on the mother's complaint of November 4 and the information he received from Dr. Jones regarding the PEth test. Dr. Lipson included no other information. He testified he believed he had a legal duty to report Dr. Farmer to the KBML after receiving the information from Dr. Jones. On November 22, a KBML investigator came to Baptist Health to interview Dr. Farmer. Dr. Lipson was present. Dr. Farmer testified when the investigator asked him if there were any other persons he believed he should interview, he answered in the affirmative and intended to give the investigator the names of Drs. Hargrove and Hatler, but Dr. Lipson intervened and prevented him from doing so. Dr. Lipson testified he never obstructed the KBML investigation in any way. This was corroborated by the investigator at trial.[6] On that same day, the investigator for the KBML presented Dr. Farmer with an interim agreed order prohibiting him from practicing medicine until approved to do so by the KBML. Dr. Farmer signed the agreed order four days later.

Subsequently, the KBML required Dr. Farmer to enter into a five-year monitoring agreement in order to practice medicine, although he could not see patients for the remainder of his residency. This agreement included a provision that prevented Dr. Farmer from taking any drugs or alcohol including

[6] Yet and still, it remains a factual dispute, and we must consider Dr. Farmer's testimony to be true in accordance with the jury's verdict. "The testimony was highly conflicting. The jury saw and heard the witnesses and they are the judges of the credibility and the weight of their testimony." *McCoy v. Clark*, 219 S.W.2d 50, 52 (Ky. 1949).

his ADHD medication. Dr. Farmer did not sign the agreement until February 18, 2020, just under a month after he received it. He was required to see a therapist monthly and submit to random drug and alcohol tests.

Donna Lillie, Dr. Farmer's therapist, was the Chemical Dependency Coordinator at Deaconness Crosspoint, with 17 years of experience. Prior to retirement, she was a licensed clinical social worker and licensed clinical addiction counselor. She did not testify that Dr. Farmer suffered from alcohol abuse disorder. She testified Dr. Farmer insisted to her that he had never been impaired at work and that she believed him. The only diagnosis she gave to Dr. Farmer was Adjustment Disorder—a short term disorder caused by major stress events in a person's life; death of a loved one being a typical example. Lillie attributed the cause of his Adjustment Disorder to his employment problem with Baptist Health and future employment prospects. Dr. Farmer eventually completed his residency at Baptist Health on September 3, 2020, rather than the anticipated date of June 30, 2020.[7]

The jury eventually returned a verdict totaling $3.5 million in favor of Dr. Farmer. Baptist Health filed a JNOV which was denied, and the trial court entered a judgment in accordance with the verdict. Baptist Health appealed. At the Court of Appeals, the judgment was reversed. The Court of Appeals concluded the trial court erred in excluding the evidence of the PEth test results and MARR Report. Based on its own understanding of this excluded

[7] Further factual detail is unnecessary as the damages award of $3.5 million being excessive is unpreserved.

evidence, the Court of Appeals discounted the facts as the jury believed them to be and concluded the trial court had effectively allowed Dr. Farmer to present a one-sided story to the jury, denying Baptist Health the full opportunity to defend itself. According to the Court of Appeals' factual recitation, Baptist Health was nothing more than a noble actor seeking to help Dr. Farmer, a confirmed alcoholic, from himself and prevent him from potentially harming any patients. It concluded, in a perfunctory two-sentence analysis, that any issues regarding KRS 311.619 were waived by Dr. Farmer filing the lawsuit against Baptist Health. It also determined that Dr. Farmer had the burden to prove both bad faith and actual malice under KRS 311.6191. Dr. Farmer filed a motion for discretionary review which was granted. We now address the merits, and further details will be provided as necessary in our analysis.

## II. Standards of Review

We have already mentioned the standard of review from a jury verdict and motion for judgment notwithstanding the verdict. We add only that after a proper evidentiary review, an "appellate court must determine whether the verdict rendered is 'palpably or flagrantly' against the evidence so as 'to indicate that it was reached as a result of passion or prejudice.'" *Lewis v. Bledsoe Surface Min. Co.*, 798 S.W.2d 459, 461–62 (Ky. 1990) (quoting *NCAA v. Hornung,* 754 S.W.2d 855, 860 (Ky. 1988)).

Interpretation of contracts is a question of law. *Frear v. P.T.A. Indus., Inc.*, 103 S.W.3d 99, 105 (Ky. 2003). Interpretation of statutes is a question of law. *Estate of Benton v. Currin*, 615 S.W.3d 34, 36 (Ky. 2021). Accordingly, we

give no deference to the lower courts. *Id.* "[A]buse of discretion is the proper standard of review of a trial court's evidentiary rulings." *Goodyear Tire & Rubber Co. v. Thompson*, 11 S.W.3d 575, 577 (Ky. 2000). "A correct evidentiary ruling by the trial court will not be reversed even if made for the wrong reasons." *Johnson v. Commonwealth*, 694 S.W.3d 232, 242 (Ky. 2023).

## III. Analysis

### A. Issues Regarding KRS 311.6191

The chief error committed by the Court of Appeals, and advocated for before this Court by Baptist Health, concerns the interpretation of KRS 311.6191. The Court of Appeals concluded Dr. Farmer needed to show that Baptist Health acted both with bad faith and with actual malice to defeat the qualified privilege contained in the statute. Its opinion subsequently, and almost exclusively, focuses on the lack of actual malice. We disagree with this interpretation.

> Any member of the impaired physicians program created under KRS 311.616, as well as any administrator, staff member, consultant, agent, or employee of the program acting within the scope of his or her duties and without actual malice, and all other persons who furnish information to the program in good faith and without actual malice, shall not be liable for any claim or damages as a result of any statement, decision, opinion, investigation, or action taken by the program, or by any individual member of the program.

KRS 311.6191. This statute does several things at once. First, it creates one qualified privilege applicable to two distinct classes of persons—those classes being the members of an impaired physicians program, and its agents, employees, etc., and furnishers of information to the impaired physicians

program. It is a privilege, and not an immunity, as our law recognizes that the latter shields its possessor from the burdens of defending an action as such, and not merely from liability; whereas a privilege "pertains to the availability of evidence in legal proceedings, and more particularly serves as protection from the production of evidence covered by the privilege." *Maggard v. Kinney*, 576 S.W.3d 559, 566 (Ky. 2019). KRS 311.6191 contemplates the potential for lawsuits arising from "any statement, decision, opinion, investigation, or action taken by the program, or by any individual member of the program[,]" but privileges certain evidence from serving as a basis for any lawsuit according to the classes of persons recognized by the statute.

The qualified privilege will prevail for furnishers of information to the program so long as they act both with good faith and without actual malice. Contrary to the Court of Appeals' reasoning, if the General Assembly intended that actual malice had to be shown in every case, then adding a good faith condition to the second class of persons, is superfluous. The conjunctive "and" imposes a two-prong test for the qualified privilege. The absence of either prong defeats the qualified privilege. "The qualified privilege operates to allow defendants the necessary latitude to communicate freely while maintaining accountability when the defendant operates outside of or contrary to the privilege." *Toler v. Sud-Chemie, Inc.*, 458 S.W.3d 276, 283 (Ky. 2014). We fail to see why the General Assembly would extend the privilege to those furnishers of information who do so in bad faith or with actual malice. That neither achieves nor protects the legislative policy.

We generally agree with the Court of Appeals' reference to our caselaw concerning defamation for guidance in understanding this statute as it is that area of law that frequently discusses good faith and actual malice in tandem. Whether a qualified privilege exists and is, *prima facie*, applicable to the defendant is generally a question of law. *Harstad v. Whiteman*, 338 S.W.3d 804, 810-11 (Ky. App. 2011). Whether the privilege will prevail, however, is generally a question for the jury when there is evidence to put the question into dispute. *Weinstein v. Rhorer*, 42 S.W.2d 892, 895 (Ky. 1931). For example, if there is a genuine issue of material fact whether a member of an impaired physicians program took an action within the scope of his duties, then that will be a question of fact for the jury to resolve, not a question of law for the court. Or, as in this case, if there is a genuine issue of material fact as to whether Baptist Health acted in good faith when it referred Dr. Farmer to the KPHF, then that issue was properly submitted to the jury for factual resolution; it was not a legal question for the trial court. If a qualified privilege applies on its face, then it is the plaintiff's burden to demonstrate the privilege does not apply in the specific circumstances of the case. *Toler*, 458 S.W.3d at 284.

There was a genuine issue of material fact as to whether Baptist Health acted in good faith. Dr. Farmer's argument relied upon the unsubstantiated nature of the mother's complaint; the contemporaneous opinions of Drs. Hatler and Hargrove that he was not impaired on November 4; and Dr. Nims' exaggerations and falsehoods which she told the leadership on November 4 that influenced their decision to refer Dr. Farmer to the KPHF. It is well-

recognized in other areas of law which also require a good faith component that the lack of a reasonable basis in fact will defeat an assertion of good faith.

For example, the good faith exception to warrants does not apply when an officer lacks "an objectively reasonable belief in the sufficiency of the warrant and the probable cause determination. If the affidavit contains false or misleading information, the officer's reliance cannot be reasonable." *Crayton v. Commonwealth*, 846 S.W.2d 684, 687-88 (Ky. 1992). Similarly, our court has held for decades that a governmental officer is not entitled to qualified official immunity because of a lack of good faith if the reason for his conduct lacked a reasonable basis in fact. *Sheehy v. Volentine*, 706 S.W.3d 229, 240 (Ky. 2024) ("the trial court required Volentine's belief to have a reasonable basis in fact; that it is insufficient merely to assert a good faith belief. We fail to see how that is an incorrect statement of law."); *Spillman v. Beauchamp*, 362 S.W.2d 33, 37 (Ky. 1962) (allegation in complaint that circuit court had previously determined a cow to be free from disease, if true, would furnish basis for finding bad faith because it would mean there was "an absence of reasonable grounds for the officers to believe the cow to be diseased[.]").

As to the facts justifying the jury's conclusion that Baptist Health did not act in good faith, we need only refer to the testimony of Dr. Lipson and Dr. Nims. Dr. Lipson identified in his testimony two bases as to why Baptist Health took the actions that it did. On one hand, the leadership was concerned solely with what happened at the doctor visit which gave rise to the complaint, and that complaint was solely related to an allegation of impairment that Dr.

Farmer was "on something." But Dr. Lipson unequivocally testified several times that the opinions of two doctors who worked with Dr. Farmer frequently, and specifically on that day, were irrelevant to the question of whether Dr. Farmer was impaired. That is an absurd contention. So, on the other hand, the historical "data points" reported by Dr. Nims must come in to help justify actions based on an otherwise unsubstantiated allegation. Thus, the decision was not solely concerned with the events of November 4 but was rather based on a holistic evaluation of Dr. Farmer's past. When confronted with the exaggerations and, frankly, untruth of these past "data points," Dr. Lipson had to then discount them—"we weren't concerned about what was in the past"—and bring the discussion back around to the specifics of November 4. This in turn would then lead back to why the opinions of Drs. Hargrove and Hatler were not considered, and so on and so forth in a vicious, nonsensical circle.

Similarly, Dr. Nims reported to the leadership that Dr. Farmer suffered from suicidal ideation and implied that his treatment with a psychiatrist was connected with that rather than solely for his ADHD diagnosis. Dr. Lipson testified he was not aware of Dr. Laird's conclusion regarding the alleged suicidal ideation as nothing more than an out-of-context joke. He insisted, however, that had he been aware of it he would have ignored it because "suicide is not a joke." What qualifications Dr. Lipson, a cardiovascular surgeon, has to assess suicidal ideation a year after the statement was made, despite admitting he had no idea what words were said or in what context they were said, was never explained by him. It should go without saying that it begs

the question to determine Dr. Farmer suffers from suicidal ideation based on Dr. Nims' assertion that Dr. Farmer suffered from suicidal ideation. That was never a diagnosis rendered by the treating physician, Dr. Laird, or any other treating mental health professional for that matter, and thus constitutes a false statement.

Lastly, Baptist Health argues in its brief that the reason they did not drug or alcohol test Dr. Farmer either on November 4 or November 5 was their concern Dr. Farmer had left work and potentially had a drink, which would skew any results of a blood test. Maybe. But Dr. Lipson testified "no one ever said anything about alcohol," "that wasn't the question," and "we weren't sitting there thinking he was drunk." Either the leadership was concerned about alcohol, or it was not, but it cannot be both. Whatever the merits of Baptist Health's contention about an alcohol test, it fails to explain why it did not administer a drug test. The complaint was specifically about "jittery" behavior and Dr. Farmer rubbing his nose a lot. Even to a layman, these appear to be symptoms of drug use; specifically, cocaine, but it could have admittedly been some other stimulating drug ingested by snorting. There was no reasonable justification offered as to why a drug test could or should not have been administered on November 4.

Accordingly, the Court of Appeals erred in reversing the trial court because it believed Dr. Farmer had to show both bad faith and actual malice to defeat KRS 311.6191's qualified privilege. He did not have to make such a showing. Dr. Farmer only had to show either prong was not met to defeat the

privilege. The Court of Appeals' opinion, which focused almost entirely on the actual malice component and the lack of evidence for it, failed to properly consider the good faith prong and the evidence, which was certainly sufficient, that justified the jury's conclusion that Baptist Health did not refer Dr. Farmer to the KPHF in good faith because it lacked an objectively reasonable basis in fact to conclude he may have been impaired on November 4.

Since we are on the subject of KRS 311.6191, we will also consider Baptist Health's argument that the trial court improperly excluded evidence regarding Dr. Farmer's PEth test results and the MARR Report from the trial. The Court of Appeals agreed with the Baptist Health and repeatedly chided and rebuked the trial court for its decisions. We disagree with the Court of Appeals and affirm the trial court's rulings based on the conclusion that the MARR Report and PEth test results were irrelevant to KRS 311.6191.

First, to the extent Baptist Health argues the trial court erred in prohibiting it from discovering this evidence from the KPHF, that is, at worst, a harmless error. We will not burden this opinion with unnecessary analysis and, for the sake of expedience, assume without deciding that the orders were erroneous. "Erroneous rulings on discovery matters are subject to the harmless error rule of CR 61.01." *McFall v. Peace, Inc.*, 15 S.W.3d 724, 726 (Ky. 2000). The trial court ordered the MARR Report disclosed to Baptist Health by Dr. Farmer, and the MARR Report contained the PEth test results. Indeed, Dr. Farmer felt no compunction citing the PEth test results in a motion in limine filed before trial which he would not have done if Baptist Health did not already

possess that information. Because Baptist Health obtained this information in sufficient time for trial, we cannot conceive how the trial court's rulings vis-a-vis KPHF could be anything but harmless even if its decisions were in fact erroneous.[8]

Secondly, Baptist Health is not in a position to assert the trial court committed error on these issues insofar as it argues the trial court unduly restricted how and for what purpose the evidence would be presented to the jury. On April 11, 2023, Baptist Health filed a written motion to the trial court where it argued,

> The MARR Report and the MARR's diagnosis are relevant for different reasons. *Defendants do not intend to offer any evidence about either the MARR Report or diagnosis for the purpose of assessing the basis for the referral decision made on November 4, 2019.* But the fact of their existence and the factual results from them—i.e., the fact that the MARR program's evaluation resulted in a diagnosis, and the fact that the diagnosis and the MARR Report were submitted to the KBML and considered as part of the KBML's decision-making process—are highly relevant to showing that

[8] We doubt, however, the trial court's rulings were erroneous. KRS 311.619 privileges "[a]ll information, interviews, reports, statements, memoranda, or other documents furnished to or produced by the program . . . as well as all communications to or from the program, and any findings, conclusions, interventions, treatment, or rehabilitation, or other proceedings of the program[,]" from disclosure. KRS 311.619(1). The "records and proceedings of the program" are also privileged from disclosure except under three defined scenarios, none of which are present in this case. KRS 311.619(2) and (3). The Court of Appeals held Dr. Farmer waived the privilege by filing the lawsuit, but that is not an exception listed under KRS 311.619(3). This Court has held that when the General Assembly creates a privilege, then that privilege and any exceptions to it, must be strictly adhered to because to do otherwise "would itself violate the separation of powers doctrine by ignoring a valid statutory grant of privilege, which is within the legislature's purview." *Com., Cabinet for Health & Fam. Servs. v. Chauvin*, 316 S.W.3d 279, 289 (Ky. 2010). Our ruling that the evidence is irrelevant to the referral would also defeat any argument regarding implicit waiver.

> Plaintiff's damages were caused by other factors besides [Baptist Health's] referral.

(emphasis added). Baptist Health went on to say,

> there are many portions of the MARR Report that are unnecessary to present at trial . . . the ultimate diagnosis can be separated from the contents of the Report itself, just as the fact of the MARR Report's existence, and the fact that the KBML relied upon it, is separate from its contents and analysis.

Baptist Health thus renounced any intention to use the MARR Report as evidence to justify its decision on November 4, and it cannot now argue on appeal that the trial court erred in that regard.[9] A party is not permitted "to feed one can of worms to the trial judge and another to the appellate court." *Hopewell v. Commonwealth*, 641 S.W.2d 744, 745 (Ky. 1982). *Hopewell* explicitly applied this rule to a question of admissibility of evidence, where the defendant at trial took one position, then embraced a different argument on appeal. *Id.* Because Baptist Health told the trial court it had no intention of offering the MARR Report or its diagnosis to the jury in order to justify its November 4 decision, it cannot now argue that the MARR Report and the diagnosis were critical to its defense on that issue. The trial court did not abuse its discretion in refusing to admit the MARR Report and its diagnosis for that purpose.

The same reasoning applies to the PEth test results. Baptist Health told the trial court in the same April 11 filing that

[9] The Court of Appeals criticized the trial court's decision, that portions of the MARR Report would be admissible for damages but not for good faith or actual malice, as "curious," yet failed to acknowledge the distinction was made and advocated for by Baptist Health at the trial court.

> the fact that the Plaintiff had PEth testing ordered by the KPHF, and the fact that the KPHF used the results, *whatever those may be*, as the basis for the KPHF's decision to report Plaintiff to the KBML and for the KPHF's recommendation to Dr. Lipson that he was obligated to do the same *is highly relevant to Plaintiff's alleged damages*.

(emphasis added). It further stated, "Defendants have no intention of offering anything about the PEth tests into evidence for the purpose of the jury relying on the accuracy of any such test." Instead, Baptist Health argued "to introduce the fact of PEth testing to show that the fact of the test results (*whatever they may be and regardless of their reliability*) were a substantial factor in causing the damages Plaintiff has alleged and showing that Defendants' referral did not cause those damages." (emphasis added). Once again, Baptist Health will not be permitted to advocate one position in trial court and then adopt another position in the appellate courts. Baptist Health told the trial court the literal results of the PEth testing were not necessary for its case at trial; it had no intention of offering the results for the purposes of their accuracy or reliability. Instead, Baptist Health only desired the fact of PEth testing occurring and that the results, regardless of what they actually were, were a substantial factor in the subsequent actions taken by the KPHF, KBML, and Baptist Health for the purposes of damages. Therefore, the trial court did not abuse its discretion in concluding the results of the PEth testing would not be admitted at trial.

Baptist Health received what it asked for at trial. It lost at trial, proving the age-old adage "be careful what you wish for." Baptist Health desired of the MARR Report and its diagnosis that "the fact of their existence and the factual

results from them—i.e., the fact that the MARR program's evaluation resulted in a diagnosis, and the fact that the diagnosis and the MARR Report were submitted to the KBML and considered as part of the KBML's decision-making process" be presented to the jury. These facts were presented to the jury. Dr. Farmer even admitted them. Baptist Health desired of the PEth tests that the fact they were conducted and that the results substantially influenced the decision-making of the KPHF, KBML, and Baptist Health be presented to the jury. These facts were presented to the jury. Dr. Farmer acknowledged taking the tests, and Dr. Lipson testified that his report to the KBML was because Dr. Jones of the KPHF told him he should make the report, and that he in fact believed he had a legal duty to report Dr. Farmer to the KBML after being told about the test results.

Finally, the MARR Report, its diagnosis, and the PEth test results are irrelevant to the qualified privilege of KRS 311.6191. That statute, by imposing a good faith requirement upon furnishers of information to the KPHF, requires that the reporters of information do so upon an honest belief with an objectively reasonable basis in fact. Good faith cannot be established *post hoc*. A furnisher of information to the KPHF must have an honest belief upon an objectively reasonable basis in fact at the time the information is furnished to the KPHF. Facts subsequently developed have no bearing on that question.

This is well-recognized in other areas of the law. For example, whether probable cause exists at the time a search warrant is issued cannot be affected by the actual subsequent discovery of incriminating evidence. *United States v.*

*Eisner*, 297 F.2d 595, 597 (6th Cir. 1962). "It is not enough that facts as subsequently shown would have sufficed for the issuance of a warrant." *Staker v. United States*, 5 F.2d 312, 313 (6th Cir. 1925). Similarly, in the context of traffic stops, we have held "after-the-fact evidence of intoxication cannot save a stop which was not justified by reasonable and articulable suspicion at the onset[.]" *Vincent v. Commonwealth*, 706 S.W.3d 94, 104 (Ky. 2024). The principle applied in these cases applies to this case as well. The good faith of a furnisher of information to the KPHF can only be assessed based upon the facts and circumstances as they existed and were known or should have been known to the actor at the time he furnished the information.

Thus, the PEth test and MARR Report are irrelevant. This irrelevance is further underscored by Baptist Health's argument already addressed above regarding the purposes for which it desired the MARR Report and PEth tests to be admitted, which had no relation to the November 4 decision to refer Dr. Farmer to the KPHF. Dr. Lipson strenuously testified alcohol intoxication was not the concern of the leadership at the November 4 meeting. He testified Dr. Hatler's and Dr. Hargrove's opinions that Dr. Farmer was not under the influence were irrelevant, and even if he had known about them at the time he would not have considered them. How then could the MARR Report and PEth tests vindicate Baptist Health? "We didn't think he had an alcohol problem, but it turns out he might therefore good faith." If that is a good argument, then good faith can be established on nothing more than taking a shot in the dark

so long as one manages to hit something. That is not what good faith means under any reasonable definition of that phrase.

Lastly, there is precious little scientific evidence in this record to judge the significance of the PEth test in answering whether Dr. Farmer was impaired on November 4; whether he was an alcoholic under the statutory definition;[10] or even whether his drinking, to the extent it exists, rendered him unsafe to practice medicine. There was no *Daubert* hearing conducted by the trial court, and Baptist Health does not point us to where one was requested and denied in the record. Instead, Baptist Health has consistently referred to the PEth test results in vague terms such as "very high" or even, at oral argument, "astronomically high."

Suffice it to say, this last description is not a medical term. But more importantly, even though Dr. Jones at the KPHF used the description "very high," we have nothing in this record to judge the accuracy of that interpretation. What constitutes a low PEth test result according to science and accepted medical standards? What constitutes a moderate PEth test result? Was Dr. Jones' interpretation consistent with medical science and accepted standards? Given that the KPHF has no diagnostic or treatment function, there

[10] "'Chronic or persistent alcoholic' means an individual who is suffering from a medically diagnosable disease characterized by chronic, habitual, or periodic consumption of alcoholic beverages resulting in the interference with the individual's social or economic functions in the community or the loss of powers of self-control regarding the use of alcoholic beverages." KRS 311.550. The PEth test would generally be able to show alcohol consumption but could not demonstrate whether that consumption interfered with social or economic functions or resulted in loss of powers of self-control.

is even the question of how valuable Dr. Jones' description of the test result is as a medical fact; in other words, Baptist Health treats Dr. Jones' description as gospel truth yet he was not a treating physician of Dr. Farmer, nor did he testify as an expert—he did not testify at all.

The Court of Appeals apparently thought the PEth test result and AUD-Mild diagnosis were conclusive in establishing Dr. Farmer had a drinking problem yet, without any explanation of the science and medical standards to put the result in context, such a conclusion is far from proven.[11] None of these questions or concerns are answerable from the record because Baptist Health accepted and advocated to the trial court that the PEth test results did not matter and sought only to admit the fact that PEth testing was done and influenced subsequent decision-making. Therefore, the trial court did not abuse its discretion in prohibiting the MARR Report and PEth test results from being heard insofar as those pieces of evidence had nothing to do with Baptist Health's decision-making on November 4.

### B. Policy of KRS 311.6191

One final point regarding this statute. There may be some concern that reinstating the jury's verdict will be detrimental to the General Assembly's purpose of providing for effective treatment of physicians who may be suffering

[11] And based on the DSM-5's list of symptoms for diagnosing AUD-Mild, which only require two of eleven symptoms present at least once in the prior twelve months, there is a host of potential scenarios that could have served as the basis for Dr. Farmer's AUD-Mild diagnosis from MARR that have no relation to his ability to safely practice medicine.

from some impairment. That is not true, and such a belief too narrowly conceives the General Assembly's policy.

The KPHF is not an investigative body, as testified to by Dr. Tina Simpson, the Medical Director of the KPHF. Its purpose is to help any physician in the Commonwealth who may be suffering from *any* kind of impairment to their ability to safely practice medicine. Even in cases where the impairment is alleged to be emotional or mental, drug or alcohol testing is performed. Dr. Simpson testified every doctor who is referred to or comes to KPHF voluntarily is tested for alcohol and drugs as a matter of course. It would seem this testing is paid for by the physician himself.[12] This testing is not performed by the KPHF, however, and the KPHF has no diagnostic or treatment function.

By creating a privilege applicable to two classes of persons, i.e., the KPHF and its employees, agents, etc., and furnishers of information to the KPHF, and then conditioning this privilege upon two separate tests, the General Assembly was deliberate in what it was seeking to protect, and how. The KPHF enjoys a privilege so long as it acts within the scope of its duties and without actual malice. A furnisher of information enjoys the privilege if it acts in good faith, i.e., it must have an honest belief with an objectively reasonable basis in fact, and without actual malice. These distinctions make sense when we account for the KPHF's lack of investigative, diagnostic, and treatment functions.

[12] The costs of testing were listed in Dr. Farmer's damages claim.

To a significant extent, the KPHF is dependent upon *what other people tell it* before it will act. This is baked into the statute itself. Read it carefully and one will see that it says neither an impaired physicians program, and its agents, employees, etc., or persons who furnish information to the program in good faith and without actual malice, will "be liable for any claim or damages *as a result of* any statement, decision, opinion, investigation, or action *taken by the program, or by any individual member of the program.*" KRS 311.6191 (emphasis added). In other words, the statute presumes that the KPHF will act on the information it receives, and that is why subsequent action of the KPHF does not, in and of itself, defeat a tort claim when brought against the furnisher of information.

In a word, for the KPHF to function properly the people who report information concerning a physician must do so in good faith and without actual malice. The KPHF does not have the resources or ability to investigate claims and verify them, or to make medical diagnoses or treatments. It functions very much like an honor system. Therefore, the law does not protect those who furnish information in bad faith or with actual malice because when they do so, the KPHF is unwittingly dragooned into being the means by which some improper end is obtained, or some unfounded report is considered and wastes resources. To protect the integrity and limited resources of the KPHF and ensure that only those physicians who are impaired get help, it is critical to the General Assembly's overall purpose that furnishers of information to the

KPHF do so in good faith and without actual malice, which is exactly what KRS 311.6191 requires.

### C. Tortious Interference with Prospective Business Relations and Breach of Contract Claims

Does tortious interference with prospective business relations encompass claims that one party interfered with another party's relationship with a state licensing agency? Baptist Health argues tortious interference only applies to voluntary economic relations thus, the tort does not apply as Dr. Farmer's relationship with the KBML is involuntary, citing *Westwood v. City of Hermiston*, 787 F. Supp. 2d 1174, 1189 (D. Or. 2011), *aff'd*, 496 F. App'x 728 (9th Cir. 2012). *Westwood* involved a "an establishment in Hermiston, Oregon, selling flowers, coffee, and sandwiches[,]" which then changed locations and became a restaurant and bar. *Id.* at 1180. The restaurant applied for a Temporary Use for Annual License with the Oregon Liquor Control Commission involving operating an outdoor beer garden during some kind of motorcycle rally. *Id.* at 1181. The Chief of Police of Hermiston recommended to the Commission that the temporary license be denied because of the host of police calls to the bar in the preceding year, including twenty-two fights, three medical emergencies, two criminal assaults, and a cornucopia of other minor incidents. *Id.* at 1181-82. Upon these facts alone, we find *Westwood* highly distinguishable and of little value in answering the question presented to us. Neither party has cited a decision from any court answering the specific

question presented. It seems to be a novel one in the entirety of the law, and not merely in Kentucky. As such, we must return to first principles.

This Court has adopted the Restatement (Second) of Torts §§ 766B, 767, and 773, as "the prevailing law of Kentucky[,]" regarding tortious interference with prospective business relations claims. *Nat'l Collegiate Athletic Ass'n By & Through Bellarmine Coll. v. Hornung*, 754 S.W.2d 855, 857 (Ky. 1988). Comment *c* to § 766 states the interests to be protected

> include any prospective contractual relations, except those leading to contracts to marry (see § 698), if the potential contract would be of pecuniary value to the plaintiff. Included are interferences with the prospect of obtaining employment or employees, the opportunity of selling or buying land or chattels or services, and any other relations leading to potentially profitable contracts. Interference with the exercise by a third party of an option to renew or extend a contract with the plaintiff is also included. Also included is interference with a continuing business or other customary relationship not amounting to a formal contract.

Thus, "[o]ne who intentionally and improperly interferes with another's prospective contractual relation . . . is subject to liability to the other for the pecuniary harm resulting from loss of the benefits of the relation, whether the interference consists of

> a) inducing or otherwise causing a third person not to enter into or continue the prospective relation or
>
> (b) preventing the other from acquiring or continuing the prospective relation.

*Cullen v. South East Coal Co.*, 685 S.W.2d 187, 189-90 (Ky. App. 1982) (quoting Restatement (Second) of Torts § 766B) (emphasis removed). The animating principle of tortious interference with prospective business relations since its first precedents in the fourteenth century has been: "he that [improperly]

hinders another in his trade or livelihood is liable to an action for so hindering him[.]" *Keeble v. Hickeringill*, 103 Eng. Rep. 1127, 11 East 574 (1707) (Holt, C.J.).

There are seven factors typically considered in this claim, but the weight given to each varies from case to case. The seven factors are

> (a) the nature of the actor's conduct,
>
> (b) the actor's motive,
>
> (c) the interests of the other with which the actor's conduct interferes,
>
> (d) the interests sought to be advanced by the actor,
>
> (e) the social interests in protecting the freedom of action of the actor and the contractual interests of the other,
>
> (f) the proximity or remoteness of the actor's conduct to the interference and
>
> (g) the relations between the parties.

Restatement (Second) of Torts § 767. Finally, and importantly,

> [e]ven if evidence is presented which would otherwise make a submissible case, the party whose interference is alleged to have been improper may escape liability by showing that he acted in good faith to assert a legally protected interest of his own. While the party seeking recovery bears the burden of proving that the interference was improper, the party asserting a right to protect his own interest bears the burden of proving his defense.

*Hornung*, 754 S.W.2d at 858. In contradistinction to the law in this case regarding KRS 311.6191, "malice may be inferred in an interference action by proof of lack of justification." *Id.* at 859; *see also* Comment *s*, Restatement (Second) of Torts § 766 ("what is meant is not malice in the sense of ill will but merely 'intentional interference without justification.' Malicious conduct may

be an obvious type of this interference, but it is only one of several types."). Thus, Baptist Health bore the full weight of demonstrating good faith.

The question presented here is whether Dr. Farmer's relationship with the KBML is protected by the law of tortious interference. There is no other argument. We conclude an actor can be held liable for tortious interference with prospective business relations when the improper interference concerns a state licensing agency's relationship with its licensee.

The KBML is the licensing authority for all physicians practicing medicine in Kentucky. No physician may practice medicine without the KBML's express approval. *See generally* KRS 311.571. Baptist Health argues Dr. Farmer does not have a contract or potentially profitable business expectancy with the KBML. Those are not the only relationships protected by the law. A physician's relationship to the KBML is easily categorized as "a continuing business *or other customary relationship* not amounting to a formal contract." Comment c, Restatement (Second) of Torts § 766B (emphasis added). Although not contractual in nature, the KBML is designed "to regulate, control and otherwise discipline the licensees who practice medicine and osteopathy within the Commonwealth of Kentucky." KRS 311.555.

This relationship certainly includes matters of trade, business, and profit within its scope. Dr. Farmer's ability to practice medicine in Kentucky and make a living utilizing the extensive and expensive education he underwent to become a doctor, depends, at bottom, upon the KBML's opinion of him. Moreover, we are not in the 19th century anymore where a person of ill-repute

in one place might move to a different state and attempt to establish himself anew. Every other medical licensing board in the other forty-nine states in the Union will look to the KBML's relationship with Dr. Farmer to form an opinion as to his qualification to practice medicine and make a living in their jurisdiction. Every potential employer in the Union will have access to the National Practitioner's Data Bank so as to form an opinion about whether he is fit to be employed at their hospital or practice. Even if Dr. Farmer desired to start his own practice and be his own boss, his ability to make a living in that career path is still predicated upon his relationship with the KBML.

This is a generally good system as it serves to weed out and prevent bad and incompetent doctors from inflicting their evil and incompetence upon innocent people. But, like all human institutions, it is not without its imperfections. In the case of Dr. Farmer, it has served to brand him with the proverbial scarlet letter. Every potential employer will now see the National Practitioner's Data Bank report stating Dr. Farmer is "unable to practice safely by reason of alcohol or other substance abuse" despite no evidence whatsoever that Dr. Farmer's drinking, to the extent it exists, ever interfered with his practice. Every potential employer will have to factor that into their decision-making regarding hiring him. Every malpractice claim against Dr. Farmer for the rest of his career, decade after decade, will include renewed inquiries into what happened at Baptist Health on November 4, 2019. All such claims will also potentially give rise to a negligent credentialing claim against his employer, and there will be *prima facie* evidence for it by virtue of the KBML's branding;

all of which will have been precipitated by Baptist Health's decision to refer him to the KPHF.

It is admitted that there is nothing that Dr. Farmer can do to remove the notation in the National Practitioner's Data Bank. "The days of the far-off future [will] toil onward, still with the same burden for [him] to take up, and bear along with [him], but never to fling down; for the accumulating days, and added years, [will] pile up their misery upon the heap of shame." Nathaniel Hawthorne, *The Scarlet Letter* 91 (Houghton, Mifflin and Company 1892). Such emotional distress and reputational harm are recognized in the damage calculation for a claim of tortious interference. Restatement (Second) of Torts § 774(A)(1)(c).

Secondly, if one peruses the applicable sections of the Restatement (Second) of Torts, one will find scant mention of a "voluntary" contractual relation as a necessary element to find tortious interference. The word voluntary appears only once and in context says:

> The expression, prospective contractual relation, is not used in this Section in a strict, technical sense. It is not necessary that the prospective relation be expected to be reduced to a formal, binding contract. It may include prospective quasi-contractual or other restitutionary rights or even the voluntary conferring of commercial benefits in recognition of a moral obligation.

Comment *c*, *supra*, §766B. This section appears to us to favor recognizing Dr. Farmer's claim. No one has a *right* to become a doctor; they must pass through numerous tests, examinations, and other trials over a period of years, the failure of one at any point can doom the entire endeavor. Nonetheless, there is a general expectation that a person who satisfies the criteria to become a

doctor will receive a license absent a statutory basis for denial. *See* KRS 311.571 (qualifications); KRS 311.595 (grounds for denial); *Abul-Ela v. Ky. Bd. of Med. Licensure*, 217 S.W.3d 246 (Ky. App. 2006) (recognizing due process right to notice and hearing prior to being denied a license to practice medicine). In this sense, it can be said that receiving a medical license is a conferral of commercial benefits—practicing medicine for profit—in recognition of an obligation on the part of the KBML that one who is eligible to practice medicine in Kentucky, and without any grounds to deny the license, ought to be so licensed.

Lastly, we disagree with Baptist Health's characterization of the relationship between Dr. Farmer and the KBML as involuntary, even were that relevant. Typically, when one thinks of involuntary economic relations, one thinks of slaves, children, and certain kinds of mental incapacitation that may affect individuals. In all these cases, the capacity of the individual as a free moral agent was or is denied when it comes to the ability to contract, to be sued, and to own and exercise dominion over property. Dr. Farmer, however, and the scores of other physicians in the Commonwealth seeking to apply their skills and make a living, do so with full knowledge that they must be licensed by the KBML. Every aspiring medical student must realize this, so it is difficult to say this relationship is involuntary. We are quite hesitant to endorse the idea that simply because a profession is regulated that the relationship between regulator and the regulated is therefore involuntary.

Contrary to Baptist Health's contention, it makes a great deal of sense that the relationship between Dr. Farmer and the KBML should be protected because it goes to the heart of an individual's ability to make a living within his chosen profession. Dr. Farmer's case amply demonstrates this, but it is equally true of a myriad of other economic endeavors that are also regulated by the state. Take beauticians for example, who must be licensed by the Board of Cosmetology after several hundred hours of training and two exams. KRS 317A.050. This is a middle-class, or even working-class profession. It is not implausible that for many cosmetologists, nail technicians, etc., obtaining their license required a significant expenditure of what little money they possessed. Now suppose a false complaint is filed by a disgruntled customer with the Board of Cosmetology. KRS 317A.140 (grounds for suspending license). That cosmetologist's welfare, her ability to pay her bills and feed her children, is now placed in jeopardy, and may involve significant expense to defend herself. Why should the law of tortious interference with prospective business relations not protect her? Has the complainant not improperly interfered with her prospective business relations by dint of striking at the root of her ability to be in business at all? It is because a state licensing agency has such a great deal of power over an individual licensee's ability to practice their profession that improperly interfering with that relationship poses a greater economic threat to an individual than interfering with any one business deal, or with any one customer.

As society grows in complexity, the common law grows with it. *Hilen v. Hays*, 673 S.W.2d 713, 717 (Ky. 1984). The rule we announce today is a new one for Kentucky and may be novel throughout the country; if so, we nonetheless affirm with Sir Frederick Pollock, "the branches grow indeed, but they have always grown from the same root." Pollock, Sir Frederick, *The Genius of the Common Law* 8 (The Lawbook Exchange, Ltd. 2019) (1912). From its beginnings, the rule against tortious interference with prospective business relations has sought to protect the individual's ability to make a living or practice their profession free from improper hindrance. Improperly interfering with that ability through a state licensing agency poses just as much, if not a greater threat than interference with one discrete contract or with one prospective customer. Thus, we conclude the law does extend to this relationship; and "armed and expectant . . . ready to close, at one swift motion, to the fighting grasp[,]" does protect it from improper interference. *Id.* at 2.

Next, we address the question of the breach of contract claim. The Court of Appeals concluded KRS 311.6191 applied to the breach of contract claim. That statute states,

> Any member of the impaired physicians program created under KRS 311.616, as well as any administrator, staff member, consultant, agent, or employee of the program acting within the scope of his or her duties and without actual malice, and *all other persons who furnish information to the program in good faith and without actual malice, shall not be liable for any claim or damages as a result of any statement, decision, opinion, investigation, or action taken by the program, or by any individual member of the program.*

(emphasis added). We conclude the Court of Appeals erred. The lower court's decision was based on its determination that the statute applies to "all claims arising from the referral [to the KPHF], including for breach of contract." This fundamentally misconstrues Dr. Farmer's breach of contract claim which did not arise from the referral but to Baptist Health's refusal to test him for drugs or alcohol prior to the referral. Equally true is the decision to refuse testing was not an action "taken by the program, or by any individual member of the program[,]" so the statute cannot apply to Baptist Health's failure to drug/alcohol test him prior to making the referral.

Accordingly, Dr. Farmer did not have to demonstrate bad faith or actual malice, as those terms are used in KRS 311.6191, to succeed on his breach of contract claim. Although there was some dispute at trial as to whether the "Fitness for Duty & Drug Testing Policy" was applicable "for any employee[,]" or the "Medical Staff/Allied Health Practitioner Health Policy" applied to Dr. Farmer's case, the distinction is immaterial. Under either policy, Baptist Health breached. It manifestly failed to test for drugs or alcohol, and it failed to conduct an investigation prior to concluding there was sufficient evidence of impairment. Dr. Lipson twice testified there was no investigation, and Dr. Nims affirmed that she was not tasked with investigating the mother's complaint and had no obligation to interview Dr. Farmer or any of his colleagues. The jury was entitled to believe them. Therefore, the jury award was not flagrantly or palpably against the evidence. Finally, the jury instructions did not specifically refer to the "Fitness for Duty & Drug Testing Policy" or the "Medical Staff/Allied

Health Practitioner Health Policy" but merely referred to the Residency Agreement between Dr. Farmer and Baptist Health. Baptist Health's proposed jury instructions did not make any such distinction either, but also only referred to the Residency Agreement. Therefore, the only legal question regarding the breach of contract claim being resolved, the Court of Appeals is reversed on this issue.

**D. Causation Argument is Unpreserved**

Baptist Health contends this issue is preserved through its proposed jury instructions. We disagree. Objections to jury instructions take two forms: sufficiency, or lack thereof, of evidence at trial, or to misstating the law in the text of the instruction.

> [T]here are two types of instructional errors and . . . each type is reviewed under a different standard. When the alleged error is that a trial court either gave an instruction that was not supported by the evidence or failed to give an instruction that was required by the evidence, the correct standard of review is abuse of discretion.
>
> …
>
> However, when the alleged error is that the text of the jury instruction did not accurately present the applicable legal theory, we review the instruction de novo.

*Kentucky Guardianship Adm'rs, LLC v. Baptist Healthcare Sys., Inc.*, 635 S.W.3d 14, 35 (Ky. 2021). Baptist Health's argument regarding causation does not fall into either of these two categories. Rather than being based on an alleged insufficiency of evidence or a misstatement of law, Baptist Health's argument regarding causation is that its referral to the KPHF was not a proximate cause of Dr. Farmer's injuries because the KPHF and KBML took independent action

after the referral which were superseding causes to any injury Dr. Farmer may have suffered. As such, Baptist Health's argument was a question of law that should have been presented in a motion for directed verdict. *Miller ex rel. Monticello Banking Co. v. Marymount Med. Ctr.*, 125 S.W.3d 274, 287 (Ky. 2004) (citing *House v. Kellerman,* 519 S.W.2d 380 (Ky. 1974)) ("Whether an intervening event is a superseding cause is a legal issue . . . so it is improper to instruct the jury to determine which of two possible events was the legal cause of the injury."); *Williams v. Courier-J. & Louisville Times, Inc.*, 399 S.W.2d 467, 469 (Ky. 1965) ("We conclude that the directed verdict was proper because Williams did not establish that the appellee's negligence, if any, was the proximate cause of his fall.").

Had this procedure properly been followed, then there were two hypothetical paths that could have been taken. First, the trial court may have agreed with Baptist Health's argument and directed a verdict in its favor. Alternatively, if the trial court decided there was no superseding cause so as to absolve liability, then it would have been incumbent upon Baptist Health, at the proper time, to request the trial court to "instruct the jury to determine whether the tortfeasor's negligence was a substantial factor in causing the event that, as a matter of law, caused the injury." *Monticello Banking*, 125 S.W.3d at 287.

Baptist Health's motion for directed verdict did not include the issue of superseding cause or a lack of proof for proximate causation. Its motion at trial concerned only an alleged insufficient showing for bad faith or actual malice,

and a challenge to the proof regarding the damage category for lost wages claimed by Dr. Farmer. Its JNOV motion failed to make a superseding cause argument as well.

Baptist Health's argument that this issue is preserved through its proposed jury instruction which would have authorized damages "sustained as a direct result of Defendants' actions in referring him to KPHF on November 4, 2019[,]" is incorrect. The trial court issued an instruction using the typical "but-for" causation language familiar to every first-year law student. Baptist Health's jury instruction does not properly preserve the argument because it misstates the law and is erroneous. *Norton Healthcare, Inc. v. Disselkamp*, 600 S.W.3d 696, 709 (Ky. 2020). "Direct result of" is not the standard of causation.

First, there is some doubt that "direct result of" and "but-for" are meaningfully different, which would also fail to preserve the issue. *Id.* We have previously defined "but-for" causation as "the existence of a direct, distinct, and identifiable nexus between the defendant's breach of duty (negligence) and the plaintiff's damages such that the event would not have occurred 'but for' the defendant's negligent or wrongful conduct in breach of a duty." *Patton v. Bickford*, 529 S.W.3d 717, 730 (Ky. 2016). For example, Person A punches Person B in the face and breaks his nose. Person B has a cause of action against Person A. It is immaterial whether the instruction would state "but for Person A punching Person B in the nose, he would not have been injured" or "Person B's injury was a direct result of Person A's punching him in the face." That's a semantic distinction without any substantive difference.

Secondly, however, even to the extent there could be a difference between but-for causation and direct-result-of causation, the latter is not the law and unduly constrains it. Our law attaches liability to "the collective cause or causes for which it lays responsibility on some person or persons." *Id.* (quoting *House v. Kellerman*, 519 S.W.2d 380, 382 (Ky. 1974)). "A superseding cause is an intervening independent force; however, an intervening cause is not necessarily a superseding cause." *NKC Hospitals, Inc. v. Anthony*, 849 S.W.2d 564, 569 (Ky. App. 1993). "The basic premise of a superseding cause is that it is 'extraordinary and unforeseeable.'" *Williams v. Kentucky Dep't of Educ.*, 113 S.W.3d 145, 151 (Ky. 2003) (quoting *House v. Kellerman,* 519 S.W.2d 380, 383 (Ky. 1974)).

As such, we have held that an actor's conduct is a "legal cause of harm to another if

> (a) his conduct is a *substantial factor in bringing about the harm,* and
>
> (b) there is no rule of law relieving the actor from liability because of the manner in which his negligence has resulted in the harm."

*Monticello Banking*, 125 S.W.3d at 287 (quoting *Deutsch v. Shein,* 597 S.W.2d 141, 144 (Ky. 1980) and Restatement (Second) of Torts § 431)). The fact that the harm may have been "brought about through the intervention of another force" is not, in and of itself, enough to absolve liability. *NKC Hospitals*, 849 S.W.2d at 569 (quoting Restatement (Second) of Torts § 442B)). Thus, "substantial factor" in bringing about the *harm* is the proper, articulable standard, not "as a direct result of." The trial court's instructions used the

"substantial factor" language. Had Baptist Health properly gone about preserving the issue of superseding causes to the trial court then the issue would have slightly changed. When a "trial court has held that the intervening event was not a superseding cause[,]" then the instruction should be framed so as to require "the jury to determine whether the tortfeasor's negligence was a substantial factor in causing *the event* that, as a matter of law, caused the injury." *Id.* (emphasis added).

For all the above reasons, causation is not preserved. The jury instructions were not a proper method for bringing the issue of superseding causes to the trial court because "[s]uperseding causation, as such, is never submitted to the jury[.]" *NKC Hospitals*, 849 S.W.2d at 569. The jury instructions, to the extent they may have presented that issue, did so in an insufficient manner for preservation by articulating an erroneous standard of law. The argument regarding causation is not entitled to appellate review and we decline to address it further. *Grubb v. Smith*, 523 S.W.3d 409, 430 (Ky. 2017).[13]

[13] We also note that insofar as some might argue we should accord palpable error review, the law does not so compel us. CR 61.02 only says that an unpreserved error "may be considered" by this Court; it is discretionary. Moreover, "[t]he language of CR 61.02 is identical to its criminal law counterpart, RCr 10.26, and we interpret that language identically." *Nami Resources, L.L.C. v. Asher Land and Mineral, Ltd.*, 554 S.W.3d 323, 338 (Ky. 2018). We have held that palpable error review in the criminal context will only be granted upon request and proper briefing of the issue; only extreme circumstances will negate that requirement. *Shepherd v. Commonwealth*, 251 S.W.3d 309, 316 (Ky. 2008). None of these elements are present.

Lastly, we briefly note that any objection to the $3.5 million award as excessive was also unpreserved. Baptist Health did not advance this argument in its briefing before this Court. Nonetheless, we note for claims of excessive damages a party is "required to make a specific objection to the jury instructions or tender proposed instructions reflecting a different award limit." *Gibson v. Fuel Transport, Inc.*, 410 S.W.3d 56, 61 (Ky. 2013); *see also Gersh v. Bowman*, 239 S.W.3d 567, 574 (Ky. App. 2007) ("Gersh's claim that the jury's damages award for Bowman's pain and suffering is excessive was not preserved for appellate review, because he failed to specifically object to the 'not to exceed $2,000,000.00' provision and the jury did, in fact, award $2,000,000.00."). Baptist Health did not make a specific objection to the jury instructions regarding the calculation of damages, and its own tendered instructions did not provide an alternative amount. The issue is unpreserved, and we will not address it further.

## IV. Conclusion

This case presented several novel issues. We as jurists must resist the temptation to neatly compartmentalize everything into one legal rule or another, especially in novel circumstances, because society and human relations all too often defy such neat categorization. "The tendency of a given act to cause harm under given circumstances must be determined by experience. And experience either at first hand or *through the voice of the jury* is continually working out concrete rules[.]" Holmes, Oliver Wendell Jr., *The Common Law* 162 (The Lawbook Exchange Ltd., 2010 (1881) (emphasis added).

The jury has spoken and found in favor of Dr. Farmer. We "exercise extreme caution in interfering with the verdicts of juries, and . . . an appellate court should hesitate not only because of the delicacy of undertaking to set aside the finding of the constitutional triers of fact, but because of the concurrence with the jury of the judge presiding at the trial." *Louisville & N.R. Co. v. Fox*, 74 Ky. 495, 516 (1874).

Discerning no legal error or abuses of discretion, and mindful that conflicting testimony presents an issue of fact for the jury to resolve, we cannot say this verdict was palpably and flagrantly against the evidence. *Bledsoe Surface Min. Co.*, 798 S.W.2d at 461–62. For the aforementioned reasons, we reverse the Court of Appeals. The trial court's judgment, including the $3.5 million award, is reinstated.

All sitting. Lambert, C.J.; Nickell, and Thompson, JJ., concur. Bisig, J., dissents by separate opinion which Goodwine and Keller, JJ., join.

BISIG, J., DISSENTING**:** I must respectfully dissent. This case centers around the important balance between assurance of patient safety in a healthcare setting and the privacy and procedural fairness afforded to a resident physician. I am mindful of the vulnerable position of a sick individual seeking necessary medical care juxtaposed with the importance of reputation to a physician and the potentially long-term consequences of being unjustly accused of impairment. The Majority Opinion leaves Baptist Health Medical Group ("Baptist Health") in a punitive paradox. Report the complaint and face lawsuit by the doctor or dismiss the complaint and have a doctor who was

diagnosed with mild substance abuse disorder actively treating patients. Between these two sensitive scenarios, certainly the law should and does promote identification, intervention, and treatment of any physician who may suffer impairment.

As outlined by the Majority, the case involved Baptist Health's actions after a parent of a young patient initiated a complaint regarding a potentially impaired resident physician ("Dr. Farmer") treating her child that day. The incident was near the end of the work shift, so immediate on-site testing was not an option. Dr. Farmer had left. Indeed, they could have directed Dr. Farmer to return to the hospital; however, any test results would be inconclusive as to current impairment because of the gap in time and his absence from the healthcare setting. While the Majority Opinion's factual overview correctly outlines some questionable decisions by Baptist staff in not conveying the full scope of information to the administrative decision makers, none of these shortcomings impact the fact that Dr. Farmer had a prior history of a DUI and a patient reporting he seemed "on something" during a visit. Baptist Health decided to report the incident to the Kentucky Physician Health Foundation ("KPHF"). The KPHF serves to identify and assist Kentucky physicians with any mental, physical, or substance-related problem that may impair their ability to safely practice medicine. The ultimate outcome of the reporting was a positive PEth test (which analyzes an individual's alcohol consumption over a long period of time), a mild alcohol use disorder diagnosis and an agreed resolution with the medical licensing board. Despite these

undisputed facts, the act of reporting resulted in significant exposure via a lawsuit filed by Dr. Farmer against Baptist Health in Jefferson Circuit Court. In the lawsuit, Dr. Farmer claimed breach of contract and tortious interference with a prospective business advantage. A jury found in favor of Dr. Farmer and awarded damages of $3,736,044. The Court of Appeals reversed this finding and directed a verdict on behalf of Baptist Health. I would affirm the Court of Appeals, but for different reasons.

Simply stated, I would find that while statutory immunity likely applied to Baptist Health's actions in this case, such a finding is rendered unnecessary by the fundamental lack of causation that is fatal to Dr. Farmer's claims. I disagree with the Court of Appeals that the trial court's evidentiary rulings were erroneous and would find the trial court properly excluded the KPHF and Metro Atlantic Recovery Residences ("MARR") records as irrelevant. I would further find that the trial court erred in instructing on Dr. Farmer's tortious interference claim, as the requirement that a physician be licensed with the KBML is a step removed from actively interfering with prospective employment. However, while I briefly address each of these issues for clarity in my overall analysis, the outcome of this case firmly rests in the clear fact that Baptist Health's actions were not the root cause of Dr. Farmer's damages.

In review, this case arose when the mother of a juvenile patient reported to a senior nurse at Baptist Health that she believed Dr. Farmer was "on something" and exhibiting symptoms of irregular behavior. Dr. Farmer's co-workers believed his behavior that day was normal. With minimal investigation

and a meeting of administrators, Baptist Health referred Dr. Farmer to the KPHF. The KPHF then sent Dr. Farmer to a third-party facility for blood testing. He had a concerning reading on a PEth test. Ultimately, Dr. Farmer was required to undergo a 96-hour inpatient evaluation at the MARR, where he was diagnosed with mild alcohol use disorder. As a result of this, Dr. Farmer entered a "contract letter" with KPHF and a "letter of agreement" with KBML that required him to abstain from alcohol and mood-altering drugs, as well as submit to random drug screens, therapy, and psychiatric appointments. Dr. Farmer did not fail any further tests and was able to successfully complete his residency.

The Court of Appeals concluded that KRS 311.6191 does not provide immunity from suit but rather only a privilege from liability if the plaintiff fails to show the communications at issue were made with an absence of good faith and actual malice. KRS 311.6191 provides:

> Any member of the impaired physicians program created under KRS 311.616, as well as any administrator, staff member, consultant, agent, or employee of the program acting within the scope of his or her duties and without actual malice, and all other persons who furnish information to the program in good faith and without actual malice, shall not be liable for any claim or damages as a result of any statement, decision, opinion, investigation, or action taken by the program, or by any individual member of the program.

The Court of Appeals found that Dr. Farmer failed to show that Baptist Health either knowingly or recklessly submitted false information to the KPHF. The Court of Appeals also found that Dr. Farmer failed to show that Baptist Health acted with bad faith or actual malice. The Court of Appeals held that

the trial court erred in not granting a directed verdict as it completely lacked any evidence of bad faith.

I disagree. I would find that KRS 311.6191 provides immunity to Baptist and not just a privilege. Because the statute exempts a qualified person from "any claim or damages," I think this refers to avoiding the burden of litigation itself and not only liability.

> Immunity is generally understood at law as [a]ny exemption from a duty, liability or service of process; esp., such an exemption granted to a public official or governmental unit . . . . [I]mmunity entitles its possessor to be free from the burdens of defending the action, not merely . . . from liability. By contrast, a privilege pertains to the availability of evidence in legal proceedings, and more particularly serves as protection from the production of evidence covered by the privilege.

*Maggard v. Kenney*, 576 S.W.3d 559, 566 (Ky 2019) (internal quotations and citations omitted).

Unlike the Court of Appeals, I would interpret KRS 311.6191, which provides that any "persons who furnish information" shall not be liable for any claim or damage, as granting general immunity where applicable. Under the reasoning in *Maggard*, it seems that the language "any claim or damages" reads like an immunity more than a privilege. An in-depth legal analysis of immunity as a matter of law did not fully occur at the trial court level. The Court of Appeals found no evidence of malice and invoked the privilege. Dr. Farmer points to Baptist Health's failure to conduct a test itself first and its failure to include statements from his colleagues to the administrators that he seemed fine were tantamount to malice in support of his claim. In contrast to the conclusions of the Court of Appeals, these failures may have raised issues

of bad faith. Yet even considering these facts, I would likely find that KRS 311.6191 provides an immunity and not just a privilege, or remand so that the trial court should make more specific findings relative to its application. I reiterate that the lack of causation eliminates the need to decide the issues based on immunity.

I pause to note that Dr. Farmer alleges the issue of causation is not preserved for appellate review. Again, I disagree. Baptist Health preserved this causation issue via its jury instructions plainly tendered to the trial court. In its instructions, Baptist Health requested the trial court instruct the jury on the breach of contract claim to place Dr. Farmer "in the same position he would have been in had there been no breach." On the tortious interference claim, Baptist Health requested that the alleged behavior was the "actual cause or substantial factor" for his damages. Baptist Health's jury instructions included a necessary finding that the damages suffered were "as a direct result" of the fact that he was referred to the KPHF. This proffered language goes directly to causation. The actual instructions given by the court failed to include the same direct causation language.

To summarize, because of the overriding problem of causation and because no reasonable juror could conclude that Baptist Health was responsible for Dr. Farmer's damages, I would affirm the Court of Appeals' decision to reverse and remand this case for judgment in favor of Baptist Health. Without doubt, not all physicians referred to the KPHF will ultimately

be found to be impaired. It simply cannot be ignored or swept away that Dr. Farmer was diagnosed with an alcohol related problem. An

> actor's negligent conduct is a legal cause of harm to another if his conduct is a substantial factor in bringing about the harm . . . . "The word 'substantial' is used to denote the fact that the defendant's conduct has such an effect in producing the harm as to lead reasonable men to regard it as a cause, using that word in the popular sense, in which there always lurks the idea of **responsibility**, rather than in the so-called 'philosophic sense,' which includes every one of the great number of events without which any happening would not have occurred. Each of these events is a cause in the so-called 'philosophic sense,' yet the effect of many of them is so insignificant that no ordinary mind would think of them as causes."

*Pathways, Inc. v. Hammons*, 113 S.W.3d 85, 91-92 (Ky. 2003) (citations omitted) (emphasis added).

Regardless of whether Dr. Farmer was in some way incapacitated at the time the mother reported him to the nurse, and regardless of whether Baptist Health internally could have handled the matter differently, the independent tests, the outsourced diagnosis, and the required follow-up treatment were the reasons Dr. Farmer suffered negative consequences. The very problems he undoubtedly suffered were a direct result of the positive testing and diagnosis, not Baptist Health's act of referral. Had his tests been clear, he would have immediately returned to work.

Turning to the other issues, I agree with the Majority's decision that the trial court correctly excluded the KPHF and MARR records from the trial of this matter. KRS 311.619(1) makes KPHF records privileged and confidential. It provides that such proceeding shall not be subject to discovery or introduction as evidence in civil, criminal or administrative proceedings. There are

exceptions under 311.619(3), for disclosure for treatment or by written authorization by the affected physician. The trial court properly found that these records were not relevant to the issues facing the jury. Whether or not Baptist Health's referral of Dr. Farmer to the KPHF was wrongful was based upon the information known to Baptist Health at the time of the referral. Any tests conducted after-the-fact of the referral were not a part of Baptist Health's considerations. In Baptist Health's favor, the trial court permitted an agreed stipulation to be read that Dr. Farmer was required to attend a 96-hour inpatient program as well as his diagnosis of mild alcohol use disorder. This information would at least allow Baptist Health to argue that Dr. Farmer's alcohol use was the primary cause of any damages he suffered.

Finally, I would further dissent from the Majority Opinion and affirm the Court of Appeals and find that it was error for the trial court to instruct the jury on Dr. Farmer's tortious interference claim. A tortious interference with prospective business relationship claim is intended to protect "any prospective contractual relations…if the potential contract would be of pecuniary value to the plaintiff. Included are interferences with the prospect of obtaining employment…" REST 2d TORTS § 766B cmt. *See also NCAA v. Hornung,* 754 S.W.2d 855, 860 (Ky. 1988) (concluding this Restatement section reflects the law of the Commonwealth). Dr. Farmer's argument that Baptist Health interfered with prospective employment by damaging his relationship with the accrediting organization KBML is an improper application of this claim. In order to practice medicine, a physician must remain licensed by the KBML, yet

the KBML is not an employment opportunity. Dr. Farmer's theory of tortious interference is one level removed from actual interference with a potential employer. The Court of Appeals correctly recognized there is no business relationship between Dr. Farmer and the KBML. The relationship is regulatory in nature. As such, the trial court erred in giving this instruction.

In reversing the Court of Appeals and reinstating the trial court's verdict, the Majority Opinion finds "it is necessary to detail that there is no evidence in the record whatsoever that Dr. Farmer was ever impaired by drugs or alcohol while at work, or that his alcohol consumption, to the extent it exists, ever interfered with his ability to practice medicine." No evidence whatsoever completely ignores the bald fact that a patient expressed their observations immediately following an in-person visit with Dr. Farmer that he seemed odd and "on something." The patient requested to speak with a senior staff member. The patient's treatment plan was altered that day by the physician. One shudders to think of a health care facility ignoring such a report. By settled law, evidence is information that makes a disputed issue of fact more or less probable. *Hall v. Commonwealth,* 468 SW3d 814, 823 (Ky. 2015). The patient report was clearly evidence.

Furthermore, along with the evidence of the patient complaint, Baptist Health also had knowledge that Dr. Farmer had a prior DUI on his record from his hiring process. Dr. Farmer scored a "very high" PEth test the very next day. Ultimately, Dr. Farmer received an alcohol-related diagnosis. All of this supports the original patient's reported concerns. Baptist Health had nothing

to do with the initiation or making of the original complaint against Dr. Farmer. Baptist Health did not influence the positive test results. Baptist Health had no input on the outside diagnosis of alcohol abuse disorder. Baptist Health had no role in Dr. Farmer entering an agreed contract with the board.

In conclusion, while balancing a difficult set of facts, it seems clear that Dr. Farmer's outcomes were not caused by his initial referral for evaluation. Indeed, a statutory structure has been put in place by our state legislature to ensure encouragement of prompt and expeditious handling of alleged impairment issues with physicians. One can imagine the difficult dynamics at play when a professional colleague, with whom one may have a close working relationship, potentially suffers from substance abuse issues. For these reasons, Kentucky law requires certain persons and entities to report violations of KRS Chapter 311, including alcohol abuse. The current Majority Opinion has serious consequences for organizations who should appropriately report concerns of potential impairment, and the safety of the patients they serve.

Goodwine and Keller, JJ., join.

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