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AVOIDING LEGAL LANDMINES WITH NEUROSURGEON & ATTORNEY, DR. JEFFREY SEGAL

David Mandell:

Hello, this is David Mandell, host of the program. Thanks for joining us. I've got a great guest today. For those longtime listeners, you've heard from Dr. Jeff Segal before. He was one of my first guests when we launched-- in the first three in season one, and I wanted him to come back because he's always got so many interesting perspectives on things, being a physician as well as an attorney, an entrepreneur, and all the other things he has done. I'm going to go through a short bio. We'll obviously link to his full bio, and then if those of you who want more Dr. Segal can always go back to season one and listen to the first time we had him on. We talked more about his story and how he got into what he's doing.

So Dr. Jeff Segal's the chief executive officer and founder of Medical Justice. He's also board certified neurosurgeon. His MD is from the Baylor College of Medicine. And he was a spinal surgery fellow at the University of South Florida Medical School. He is a member of Phi Beta Kappa as well as the AOA Medical Honor Society. He received his BA from the University of Texas and graduated with a JD from Concord Law School with highest honors.

In the process of conceiving funding, developing and growing Medical Justice, which we're going to hear about, Dr. Segal has established himself as one of the country's leading authorities on medical malpractice issues, counterclaims, meritless board complaints, issued specific to the data bank, and internet-based assaults on reputation. We're going to talk about a bunch of those today. And he's also partner in the law firm, ByrdAdatto, a national business and healthcare law firm. We've had a couple of his partners on over the years as well. So with that, Jeff, thanks for joining us.

Dr. Jeffrey Segal:

Thanks for having me. Great to see you, Dave, and... hear you. This is a podcast, so I'm hearing you.

David Mandell:

That's right. For those of you out there listening, it's good to have you hear us. So we got into a little bit in the bio of some of the things you're helping docs with at Medical Justice and some of the other things you do. Why don't you, before we get into the specifics, kind of give an overview of what you're up to today in terms of the various ways you help doctors?

Dr. Jeffrey Segal:

All right. So at its core, I'm a physician, so I happen to be... I'm a physician who happens to also be a lawyer. So I understand healthcare. When we get a medical, legal complaint, because I'm a physician, I don't need to go to Google to try and decipher what the issue is because, mostly, these are medical issues that morph into legal problems. And when we launched, and we launched two decades ago, we were focused mostly on keeping doctors from being sued for frivolous reasons. We still do that.

But more broadly, our scope has expanded to deal with all additional types of headaches that doctors experience, all types of conflicts between doctors and patients. Issues related to the Board of Medicine, issues related to the National Practitioner Data Bank, issues related to credentialing, employer employee issues. Healthcare has changed.

It has evolved, and the types of problems that doctors can be exposed to has also mushroomed like an atomic cloud. So here we are, trying to zig and zag in the modern era. We're right now in 2023. I'd like to say... I wish I could say that the types of problems that doctors have been exposed to have gone down, and they can mostly focus on the practice of medicine, but mostly, that would be a laugh out loud type of moment for me and for your listeners.

David Mandell:

There's a bunch of different paths we can go down. We can start wherever you want, peer review data bank, medical licensing. Where do you want to start? And we'll kind of go from there and see where it takes us.

Dr. Jeffrey Segal:

Well, why don't we start with medical licensing. Because once you graduate from medical school and typically go through a residency to ultimately capitalize on your education and training and as well as experience, you will need a medical license to do so. Medical license is the gift that the... or it's not a gift. It's a right that the state government gives to you to practice your craft. And for the most part, when you are applying for a license, you're looking for a full and unrestricted license.

And once you get a full and unrestricted license, you should be able to do anything within the domain of healthcare as long as you comport with the standard of care and follow codes of professionalism. And for most people, that's pretty straightforward. But I think the flip side is that the state giveth and the state taketh away, meaning that while the state gives you the right to be able to practice your craft, they can also restrict it or, indeed, take it away. So how does that typically happen?

Typically, it happens when there's a complaint, a complaint gets filed, and we'll talk about the various types of complaints, and ultimately the board will make a determination as to whether you pose a danger to the public. And their definition of danger to the public may be different than other people's definition of danger to the public. And they may very well say, "We don't see a problem here." While somebody may have filed a complaint, a patient may have filed a complaint, a competitor may have filed a complaint, your employer may have filed a complaint, they may come to the conclusion, "We just don't see anything here. So have a nice day."

And that would be the best of all possible outcomes. But there are times when the board moves forward with an investigation to do a deeper dive, and they may ultimately conclude that there are some issues, concerns, or problems. And in doing

so, they may recommend... Well, they may actually just describe this as a reprimand, and every state treats this differently.

David Mandell:

Ok.

Dr. Jeffrey Segal:

So I'm just kind of giving you some broad strokes right here instead of being prescriptive as it relates to individual states because all states do treat this differently. But there may be a private letter of a concern. There may be a public letter of reprimand. There may be action on your ability to practice, meaning that you could have a restriction, your license could be suspended, or your license could be revoked. And as you listen to this, you can see that there's an escalating menu of options available to the state, which become bigger and bigger news. So if this is just a matter of a private letter of concern, that doesn't seem to be particularly onerous. Nobody wants that. You don't want an ugly letter in the file cabinet.

But by and large, you still should be able to go back to work the following day, still be able to perform surgery if you're able to perform surgery before, still able to see patients in your office unrestricted if you were able to see people before. And that's not a great way to end something. You would prefer to have there being no action. But if there's some action, a private reprimand or private letter of concern would be something that most people can live with. Moving up the chain is a public letter of reprimand or a public letter of admonition. Some states use different language, but by and large, they're similar. It just means we're going to tell the whole world that we've got an issue with you. And you're still able to go back to practice, and it's unrestricted.

But now you've got this mark of Cain on you, scarlet letter if you will, which says you did bad. Doesn't mean that you're a danger to the public, but it just says that something happened that was untoward, and we just want you to do better next time. Then as you go up the escalating ladder of problems, the state may actually restrict your license. It may say that you can't evaluate a patient for exam. Let's say

it's a female patient without a female chaperone in the exam room, which I still think... I think it's almost ridiculous to mandate that. But I will say that just, and the reason I say that is because every doctor should be doing that anyway, meaning that it should just be an established practice that to the extent you're seeing a patient of the opposite sex.

It's just good practice to have a third party in there. Certainly, have the patient's ascent to do that. The reason I say that is because if you don't and the patient makes an allegation you touch them inappropriately, you will burn. You will burn without a witness because nobody was there to actually break the tie of the he said-she said. You got a 'he said, she said', or 'she said, he said'. It turns out that such complaints are equal opportunity offenses, and there are just as many men filing complaints against female positions as the other way around. Welcome to 2023. But the point I'm trying to make is that you may have a restriction on your license that is not very public, which says that, in this particular example, you need to have a chaperone. And in some cases, it may be that the state has to approve the chaperone. You can't just hire a medical assistant. It may be somebody who's a nurse, somebody who is under the authority of one of the departments that the state oversees.

And then it works all the way up to your license is suspended for, let's say, X number of months while they complete an investigation. This is soon... This presumes that they believe you're a danger, but they'll give you the benefit of the doubt and due process and do a deeper investigation to the point where the worst type of escalation is that your license is revoked in that particular state. So a big laundry list of ways that the state can take action.

David Mandell:

Interesting.

Dr. Jeffrey Segal:

And I think for most physicians, this comes as a shock in many ways because, on the one hand, most people are aware of professional liability, so they have paid a

premium for med mal insurance. They're aware of the problem, and they've... most doctors have insured themselves sufficiently to manage that problem. But should you have a problem with your license, that... I would highly recommend you don't try and wing it and go solo on this because the price for getting it wrong is actually even more onerous more challenging than losing a professional liability case. Remember, your license is your ticket for making money for practicing your craft. It's an annuity, if you will.

You lose that. You lose your ability to make a living in the medical field going forward. If you lose a professional liability case, typically, your insurance carrier will pay. But even if there's overage, you may ultimately have to file for bankruptcy just thinking of worst-case scenarios. But for most people, you'll still be able to practice medicine. You'll still be able to go back and make a living. You'll still be able to put food on the table, a roof over your head, and you'll be able to carry on. But lose your ability to practice medicine, and it may very well be game over in the medical field. You may have to do something else, like working as an Uber driver or FedEx or any number of other places that do not pay as much until you get the C-suite. So the first thing is, my first recommendation is to make sure you've got some element of insurance to cover this because it doesn't come cheap. When you need a licensed defense attorney, you don't have a lot of time to shop this around, and if you're paying out of pocket, it can get expensive rather quickly.

Your typical professional liability policy may give you a writer with some money in it, 25 to $50,000 just as an add-on, if you will, for your med mal coverage. You won't know that unless you've asked the question or unless your broker has affirmatively given you that answer. So strongly recommend the answer to that question.

David Mandell:

Right.

Dr. Jeffrey Segal:

Do you have any coverage whatsoever? And I would say, if you don't have any coverage, get some coverage. If you do have some coverage, I would say 50,000 is

the bare bones minimum. But if this turns into a full-blown investigation with a hearing, you'll blow through that limit pretty rapidly. And I'd start looking at higher limits, 100 K, 200 K. You don't need... I don't think you need a million dollars of coverage like you do for professional liability, but I do think you're probably going to want more than $25,000 to get the job done.

So a quick whirlwind tour of just a single aspect of a single problem, but I did want to drive home that one point that your ability to... that your license gives you the ability to earn a living, and if that goes at risk, your entire career may be at risk. And the first thing you want to have is a lawyer who knows what they're doing, and they're properly paid, so you don't have to dig deep into your pocket just to keep him on board. Keep him or her on board.

David Mandell:

It makes total sense. It's an important takeaway. First, look at your med mal, have your broker explain it to you. Do you have some licensure coverage, right? And licensure defense, and if not, add it. And you know what you were saying, 50,000, kind of a minimum, 200,000 somewhere in that range for coverage. What do, you know... I want to move on to other topics, but are there any barriers? I mean, do you see frivolous complaints? I mean, frivolous lawsuits and it kind of makes sense economically. Someone wants to get paid, right.

"Oh, I'll sue this doc. I can get a couple bucks out of it." Right. With a licensure, I guess there... complaint, there isn't that, maybe it's more of a revenge or, "Let's do some harm to this person." Do you see that as much as an issue as it is with malpractice cases or not?

Dr. Jeffrey Segal:

Oh, yes. I do think board issues are as problematic, if not worse, as it relates to the threshold. Here's why. With a professional liability case, there are at least some rules. Typically, you need an attorney to help move this along. So there's going to be a threshold entry for an attorney to get interested in a case. It's usually money.

So if your case only has, let's say, $10,000 of damages, most attorneys are going to say, "So sorry for your problem, but there's just not enough cash in it for me to go along with you to take all the risk." And I can't... I don't blame them. I do think that the amount of effort and time it takes.

David Mandell:

Contingency base basically, right. That's the underlying assumption that they're only going to get paid on the judgment. They're not billing by the hour. So they have a financial incentive to kind of figure out is there something that's really here crudely economically, maybe more medically even, but they have some bar they got to get over to say, "Am I going to spend my time on this, essentially?"

Dr. Jeffrey Segal:

Yeah. It's an opportunity cost for them... So that's number one. Number two is that typically, with a medical malpractice lawsuit, there is a statute of limitations, meaning that there's a limited period of time for the plaintiff to file their case. Varies by state. In California, it's typically a year. North Carolina, I believe it's a couple of years. Some states, it's three years. Some states a little bit longer. Regardless, it's a finite window of time. What about for the Board of Medicine? Do they have a time limitation for which to review a case? Nope. There is no time limitation.

If there's a case related to a complaint that's eight years old, the board is certainly empowered to look into it. Their mission is to protect the public. And if they believe somehow that that case is an index, that you're a danger to the public, they are fully and totally empowered to investigate. Now, will they take an eight-year-old case? I don't know. They may or may not because records may not even be available to support your defense. Most states, you're not obligated to keep records for eight years or longer. So it may just be from a practical perspective they're not interested, but they're not barred by either statute or regulation to avoid taking that case.

And the final point is that, and we alluded to this initially, is that the board... Well, let me back up. To propel a medical malpractice case forward, the plaintiff will need to prove a number of things. One of which is that you violated a standard of care, and

that violation caused damages. What about for the Board of Medicine? They just need to demonstrate you violated a standard of care. It doesn't matter at all to them if anybody was injured by your action. So that is a substantive and significant difference.

David Mandell:

Yeah.

Dr. Jeffrey Segal:

All they need to do is say that somehow you did not follow a standard of care. If you got lucky, if the patient got lucky and there was no injury, no damages in the professional liability world, they get skunk, the patient collects $0 if they file a lawsuit, not so for the Board of Medicine, they don't care if there was... I mean, certainly if a patient died, they're going to take a bigger interest in this, but they're not foreclosed from investigating a case whether or not there were damages or not.

David Mandell:

Yeah, that is an interesting sort of legal difference. We only have so much time here. I want to move on to some of these other topics, which is peer review. You had mentioned in our notes, like when we were sharing emails about this, something called sham peer review. So I'm curious what that is, and I'm sure my doc listeners are too. So let's get into just peer review in general, and then what is sham peer review, and what should docs know about this stuff?

Dr. Jeffrey Segal:

All right, so peer review historically was a noble calling. It was a way where physicians could get together and, in complete confidentiality, discuss what went wrong with any particular case and go over it harshly, perhaps, but use that information and discussion so everybody could learn, everybody could get better. So when I was a resident, it was called death and donuts. I mean, you would go over all

the complications, morbidity, mortality, and it was always difficult to go through because you were going to be in the firing line.

You were going to get beaten up mercilessly. But the purpose, at least ostensibly, was a noble one. It was designed to make you a better doctor and was designed to educate your peers so that they would learn from this mistake and not do what you did, and hopefully, you wouldn't do what you did going forward. Everybody would learn we'd become better doctors. So that's peer review in its perfect sense, in its noble and ideal sense. But you did bring up sham peer review.

And don't get me started on sham peer review, but sham peer review is not so noble. It's a peer review process, in my estimation, which is abused for a different purpose. It's designed to get rid of a doctor using the peer review process as a means to an end, meaning that the end is not to make you a better doctor. It's not to educate. It's the excuse to get rid of a perceived problem player. Could be an individual who has identified a number of problems at an institution related to patient safety and uniquely is speaking out, describing to all the authorities all of these ticking time bombs and is concerned that doctor's concerned, that someone's really going to get injured.

And because that doctor is making some noise, the powers that be have decided just keep an eye out for this guy and wait till he gets his own complication, and we'll finish him off. And they abuse this established process to try and de-credential this particular doctor, turn this into an adverse action, get it reported to the National Practitioner Data Bank, and make that individual radioactive so they become unemployable anywhere else. The message being, "We will teach you a lesson and that you'll never cross any powerful individual ever again." Sham peer review, a very ugly process which abuses a noble process for an ignoble cause.

David Mandell:

And you mentioned the data bank there. So that's ultimately the kind of, I guess, repository of these reports and the sharp end of the stick, I guess, in that it can follow you anywhere. So give us a little information just what is the data bank, and are

some reports worse than others? And then, ideally, what should docs be thinking about if they're involved with something that involves that?

Dr. Jeffrey Segal:

Great question. So the data bank is a federal repository of information. So really important point. It's a federal repository of information that is full of information about doctors and other healthcare providers based on medical malpractice settlements and judgments. That's number one. Paid out by a carrier. Number two, adverse actions by a hospital or healthcare organization or actions on one's license by a state licensing entity.

There are other ways you get reported, but those are the biggies. And the reason the data bank was identified was because decades ago, a doctor could be bad an untalented hack really hurt a lot of people, perhaps even lose their license in a state or be kicked out from staff from a facility. And then, lo and behold, reemerge in another state, another institution, and they knew nothing about it.

David Mandell:

Right.

Dr. Jeffrey Segal:

They knew nothing about how bad that individual was. And there we go again. It's like Groundhog Day, one more round of this badness. And so people thought there must be a better way. It's interesting. I don't know if this was related to the data bank, but there was a neurosurgeon named Swango, S-W-A-N-G-O. And his initial problem, I believe he was a neurosurgery resident at Ohio State, and a lot of people ended up dead on his practice. I mean he was an intern, but a lot of elderly individuals. And while it was never proven definitively, it was felt that he was injecting the elderly people with IV medication. He'd go in to a room, and then he'd come out. These people would be dead on the way out.

And so the question was, there was certainly a lot of coincidences. They kicked him out, or they didn't renew his contract. He then worked as a paramedic. He served

time in prison. Then came out, and he was in a family practice residency and ultimately ended up at Stony Brook, where people at the VA hospital were also dying in the same way. So finally, that doctor calls up the original program director at Ohio State. He knew this guy was at Ohio State and go, "You know anything about this guy named Swango? I mean, it just seems like there's a trail of dead bodies around him." And he goes, "Yeah, yeah, we were concerned, but ultimately it just didn't renew his contract. Why? What's going on?" Well, this guy finally spoke up at Stony Brook called the authorities.

I believe he called the FBI, but I can't recall specifically. And he did investigations charged him with murder, convicted him, and now he's in... I think he's serving many decades in prison or even life in prison. But the point being is that had there been a easy data bank to share this information, it's likely that many people would not have been injured or killed. The point being that the data bank was designed as a way to allow for sharing of information so somebody couldn't just escape the consequences of their actions in one jurisdiction and reemerge elsewhere and start all over again, meaning that you'd have to explain yourself. And so that was the reason or the essence for the data bank.

David Mandell:

Yeah, it makes sense. And so if somebody, and again, you mentioned malpractice cases end up there, the licensure end cases can end up there and then a staffing issue potentially. I mean in terms of some kind of complaint or what have you. Are there certain reports that are worse than others? I guess, has liability at some point with some kind of case would end up there, but my guess is there may be some reports that are worse than others. What are your thoughts on that?

Dr. Jeffrey Segal:

Yeah, so let me just mention a couple that come to mind. So if you settle a case for professional liability, either by settlement or judgment and your insurance carrier makes the payment, if they make a payment for $2 million, that will be perceived as worse than if they make the payment for $10,000.

So the dollar value of the payout does correlate with the level of interest people put into whether they perceive you to be a danger or not, which is why that, to me, if the amount is sufficiently low and you believe that you, individually as a doctor, can actually write the check yourself without having the carrier write the check, I encourage our doctors to not rely upon their insurance carrier to make the payment, just pay it out of pocket. Because if you pay it out of pocket, it won't necessarily be reportable to the National Practitioner Data Bank.

David Mandell:

Interesting.

Dr. Jeffrey Segal:

The carrier makes the payment. They have to report it. Doesn't matter whether it's a dollar or $10 million, they're going to make the report if you make the payment that that is not reportable to the data bank. Now, if you make a payment of greater than some dollar value, depending upon which state you live in, it may be reportable to the state. So, for example, in California if you individually write a check for 30,000 or more, that ultimately can be reported to the state, and so on and so forth. So my point is that there are some forks in the road where you may have some options to avoid reportability, but let's move over to the other side, which would be hospital privileges.

If a hospital seems hell-bent on an investigation, and it looks like this may be moving to a hearing, you'll often be given a number of options. One will be you can go to the hearing and defend yourself. It may get ugly, but you will at least have narrowed down the issues, and they may rule against you and indeed might rule against you, but at least the issues would've been narrowly defined. You will often be given the option of resigning, but if you resign while under investigation, in my estimation, that is the kiss of death. That is almost the worst label that will be sent to the National Practitioner Data Bank.

The think the perception being right or wrong that you just wanted to run away, not even defend yourself, that you just ultimately thought you could disappear and

reemerge in another institution, start all over again. The problem is that it'll be reported to the data bank as resigned while under investigation. And there are a number of hospitals in the country that happen their bylaws that if you resign while under investigation, they have foreclosed from even credentialing you.

They may not even have the ability to credential you. Now, there may be some workarounds with that, but my point is you're playing defense at that point. I almost think you're better off actually going to a hearing and losing your privileges at the hearing then being labeled with this moniker resigned while under investigation. And the thing is, most doctors don't know that.

David Mandell:

Right.

Dr. Jeffrey Segal:

They have no idea. They just assume that, "Wow, I won't have to go to a hearing and actually lose my privileges. I'll just fade away into the sunset." But that fading away in 2023 with how it gets labeled to the data bank is injurious to your future career. It really does limit options for you.

David Mandell:

It's a good... very interesting point. And my guess, it would be counterintuitive to a lot of docs who haven't gone down this road. And this is why getting good counsel at that point is so valuable because, ideally, you're getting that advice, and you're making the best argument you can. Even if you lose at the licensure hearing, like you said, you've narrowed it. You have your argument.

When you go somewhere else, you can... you've got that in front, "Hey, this is why I thought I was in the right." And if an institution wants you, then they may see things a little differently. Like you mentioned before, there could be politics involved the old institution and clouding the judgment that a new institution who liked you and isn't precluded because you're not resigned under that cloud.

Dr. Jeffrey Segal:

Dave, your point is so spot on, meaning that if an institution wants you, they'll find a way to say yes. You need to make it easy for them to say yes, which would be you don't want this label resigned while under investigation. I agree with you. And the other thing is that nobody likes a surprise. If an institution is recruiting you, that means they find value in you, and they want you, and you may be going to an underserved area.

So they're only... they're delighted that somebody would take an interest in their rural hospital, for example. But nobody likes a surprise. So the way to manage this is that if you've defended yourself, and let's say it turned out poorly for you, there's at least a record associated with it, and it allows a third party to actually review it reasonably.

David Mandell:

Right.

Dr. Jeffrey Segal:

And you can explain it to them upfront in your words what happened. If you explain to them upfront, "Look, I like you, you like me, and I'd really like to work here, but before we go too deep, I want to make sure that you're informed as to my history. This is what happened." In your own words. You were describing it in your own words in advance. And when the full record comes over, they'll go, "Well, we were aware of that, then we made an informed decision. We can live with that, not the end of the world."

David Mandell:

Right. So that advice of not resigning under investigation, there's some really people should take away. Hopefully, nobody listening to this has to get into that, but they may, and they may have friends and colleagues and folks they train with, and stuff happens as they say.

Dr. Jeffrey Segal:

As they say. Yes.

David Mandell:

I'll say stuff in the podcast version of this. So what about exiting? What about negotiating exiting... exit agreements to get a fresh start, even, let's say, if it hasn't gotten to the investigation stage, but you know there's animosity. It's just not working out, let's say, right. But maybe the license issue is not at hand.

But maybe they think you're disruptive or... for whatever reason, right. I mean a business divorce in some sense. So tell me about how you approach that, as not only with your physician hat on but on with your attorney hat on. What can folks take away from that? That is probably a lot more common than-

Dr. Jeffrey Segal:

Yes.

David Mandell:

... some of these most... more edge case issues.

Dr. Jeffrey Segal:

So as in all divorces, you want some type of agreement on the way out to know what happens to the money, what happens to the kids.

David Mandell:

Right.

Dr. Jeffrey Segal:

And if you are an employee of an organization, it probably makes sense for each side to better understand what this exit looks like. It may be predefined in an entry agreement in an employment agreement, but it may not be. And I think if you're on the way out, each side should want something from the other side. You don't want to be labeled as a disruptive physician, somebody that nobody should ever want to hire

going forward, but the only way to nail that down is for each side to give something up. What you want as a physician leaving is to make sure that the other side won't badmouth you. You want a non-disparagement agreement.

And to me, the less said, the better. "Dr. Segal began work at our institution as a neurosurgeon on January 1st, 2016, and he left December 31st, 2019. His privileges were never in jeopardy at any point," and leave it at that. I mean, I think three sentences are plenty. The less said, the better. But if you don't nail that down, and we've seen this over and over again. Doctor leaves. They've agreed upon money, what the final payout's going to be, whether he gets the bonus or not, and then a future employer starts asking questions. They say, "We're thinking about hiring Dr. Segal, and he said he worked for you during this window of time. Can you tell us about him?"

If you've not nailed that down in an exit agreement, what may come back was, "Oh, Segal, are you thinking about hiring him? That would be the biggest mistake on the planet. Now you're free to make your own decision, but we danced a dance of joy on his way out the door." I mean, not helpful as you're trying to get your next job, but something that if you're going to negotiate control of the language, negotiate it before you've actually departed. That's the time to do it. And what do they get in return?

Well, it's mutual release of claims. If it's possible that they wrongfully terminated you. It could be a breach of contract. It could be issues related to a perceived Americans with Disability Act violation. The list goes on and on of how a creative attorney could find a way to sue your now former employer, and they would want to avoid any type of litigation. So each side gives up claims, and potentially a mutual non-disparagement agreement is a way for everybody to just kind of exit. "This is a divorce. This is how it works."

David Mandell:

Right. And like you're saying, I think they're already in the negotiation phase in terms of the money, right. That's being figured out, right. So you want 100% of the bonus, "Well, I'll walk away with just 80% of what I think... but I want these things." Meaning it's

all put... it's all part of the deal. And so there is certainly something in it for both sides. I mean...

Dr. Jeffrey Segal:

The money's the most contentious part of any potential challenge because there, your employer is giving something up. It means that they are not... they will not have as much in their bank account. But in terms of a mutual non-disparagement agreement, they're really not giving up much other than the psychic joy of being able to slam you.

David Mandell:

Right. Right.

Dr. Jeffrey Segal:

And well, there's probably some benefit in doing that. It's not the same as cold hard cash.

David Mandell:

Right. Yeah, I totally... That sort of was my point, which is that's where your fight's going to be, so just don't forget these things. Don't be so focused on the dollars that you say, "Oh, I got the financials I want. But oh, I never got the non-disparagement agreement." That going to come back and haunt you. So why not get that if it's...

Dr. Jeffrey Segal:

Okay, I've got one other point. I want to make sure this is a point that is

David Mandell:

Yeah. Let's do that, and then we can get to wrap up because I know you got to go, and this is about that timeframe.

Dr. Jeffrey Segal:

Yeah. So this is esoteric and arcane but really important. If you're on the way out the door from a hospital, for example, and it's just not working out. The magic's not there. Let's say you were hired as an employee, and it's just not working out. And there may be some turmoil in the background, but you think, "If I just leave now, that'll be the end of it." You want to make sure that there is no background investigation going on about you as you turn in your resignation. Here's why.

Remember what we said before. What's the worst possible thing that you could be labeled as with a data bank? It's having resigned while under investigation. So the first question is, "Well, doesn't the hospital have to notify me if I'm under investigation? Shouldn't I get an email or a letter?" And the answer is you will often get an email or a letter, but you won't always get an email or a letter. They do not have to notify you about an investigation. So if you truly do resign while under investigation and you try to come back and say, "Look, I had no idea there was an investigation," you may still be reported to the data bank. So how do you do that?

David Mandell:

Right.

Dr. Jeffrey Segal:

You can do what I call a conditional resignation. You say, "I am turning in my resignation effective December 1st, 2023, assuming or conditioned on the fact that there is no ongoing investigation right now. I don't believe there is any, but because the bylaw suggests that there's no obligation to notify a physician, please accept this resignation as conditional." That way, you haven't formally resigned unless the hospital tacitly agrees that there's no investigation.

So this is a esoteric point, but I have certainly seen doctors get burned when they're doing their data bank query down the road or trying to get a new job, and they're listed as having resigned while under investigation. Again, the worst thing in my estimation of the data bank listings and they go, "Wow, how did that happen? I had no idea." So just a step.

David Mandell:

Yeah. Yeah, that's interesting. This is why it's important to get... If you're thinking about any of this stuff or your friend, colleague, et cetera, is be talking to somebody with expertise because you can't... you don't even know the issues that exist. I don't think it's intuitive to anybody because there's so much complexity that getting steered in the right direction, even if there's nothing that you know about, is important. So Jeff, any final thoughts before we wrap?

Dr. Jeffrey Segal:

Yeah, just always get comfortable hiring an attorney. Look, nobody likes paying for an attorney. I don't either. I don't like paying for attorneys, and I am an attorney. But I do think that there are times when there's a lot riding on this, particularly your license, your credentials, your privileging, all of that is important. I think it's important to have good counsel. Not every attorney is aware of these arcane issues, for example, the data bank, but there are some who know quite a bit about it, and they're the ones you're looking for.

David Mandell:

Yeah.

Dr. Jeffrey Segal:

So that's the take-home message. Don't be shy about getting legal counsel when the stakes are quite high.

David Mandell:

I agree. Ounce of prevention. Jeff, thanks so much for being on. This is really valuable stuff, and they're really, like you said... I mean plenty of healthcare attorneys and great ones, and obviously ByrdAdatto does everything in the healthcare space. We've had your partners on. But there are lots of folks who do deals and things like that.

But this kind of compliance and proactive kind of putting out fires before they even come up or whether smoldering before they come big fires, this is not something that

even every healthcare attorney knows about. And so Jeff can be a great resource. Obviously, we'll have his... a link to his bio and Medical Justice and everything he's doing in the show notes. So Jeff, thanks for being on. Appreciate it.

Dr. Jeffrey Segal:

It's a pleasure. Thanks Dave.

David Mandell:

And to all the listeners, thank you for tuning in. Obviously, we look for good reviews and let your partners and buddies, and folks you've trained with know about this. And if you are a physician with an interesting story to tell, feel free to reach out to me. Shoot me an email, and maybe we can have you on here in the fourth season. So look for another episode in another two weeks. Thank you.