



The Case of the Overly Attentive Attending

Case by Drs. Dara Kass & Stacey Poznanski

Case

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Expert Commentaries

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Curated Community Commentary

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Samantha had always been a model student. She was top of her class in medical school and was thrilled when she matched in her top choice of Emergency Medicine residency programs. The city was far away from her family but she felt it was the best fit for her and she knew she would receive quality training.

Shortly after starting residency, Samantha began dating an orthopedic resident. They had a brief, casual relationship and after three months, it ended amicably. A few months into her second year of residency Samantha joined the orthopedic team as a required core rotation. She was excited to start ortho, as it had been one of her favorite rotations in medical school and she knew the experience would enhance her abilities as an EM physician. Her ex-boyfriend was on rotation at a different hospital so she was not concerned about any conflict affecting the team dynamic.

The first two weeks of her rotation were rather uneventful. She alternated between consults and clinic, putting forth her best effort. At night, even when post call, she took extra time to read about fractures and splinting so she could be useful to the team. She was learning, enjoying her time, and had no idea that her life was about to change.

At the start of her third week of the rotation, Samantha was in clinic seeing a patient for follow-up of a fracture reduction in the ED. She asked the attending to come into the room and confirm that the fracture was healing well. As he reviewed the images over Samantha's shoulder, he hovered close. Closer than he had before. As the patient was in the room, Samantha was certain she was imagining things and decided to think nothing of it. The attending agreed that the patient could be seen again in 2 weeks, and he dismissed the patient to the waiting room to wait for final instructions. As Samantha got up to leave,

the attending asked her to stay. There was something he wanted to review with her. Again, slightly out of the norm, but she did as she was told.

He closed the door and stood in front of it. He told Samantha he had noticed her. Noticed how hard she was working on the rotation. "A girl so pretty doesn't need to work so hard," he said. He asked if she had dated anyone since breaking up with the orthopedic resident. She was taken aback and hesitated for a moment, then stated that this was not his business and that they should move on to the next patient. But he persisted.

His language was explicit. He described intimate details of relations she had had with her ex-boyfriend. He told her she needed to be with a real man and graphically described how he would satisfy her. Samantha politely refused and commented on the inappropriate nature of their interaction. The attending physician dismissed her remarks and continued to pursue the issue.

He hovered close to her and whispered into her ear while casually brushing over parts of her body with his hand. She stood there, frozen, until a knock on the door ended the interaction. It was the nurse, asking about a new patient in the waiting room.

After he left the room, Samantha ran out of the clinic and began to sob uncontrollably when she reached the parking lot. Everything was a blur, but somehow she felt like she had brought it on herself. Perhaps she had developed a reputation because of her casual relationship with his ortho resident. Or was she being flirtatious in clinic? Were her clothing too revealing? Samantha couldn't make sense of what had just happened. She felt ashamed and didn't know what to do next.

Questions for Discussion

1. As a resident on an off-service rotation, what should Samantha do next? Should she go back to the clinic and see patients, but ask for a new attending? Does she activate sick call and go home? Should she tell someone?
2. What steps should be taken once program directors or emergency staff are made aware of this situation?
3. Are there any legal actions that should be taken at this point? Where is the line between aggressive flirtation and assault?

Competencies

ACGME	CanMEDS
Professional Values (PROF1)	Professional Collaborator

Intended Objectives of Case

1. Discuss possible policies and/or procedures for handling sexual assault incidents (or other unprofessional acts) such as the one listed in this case.
2. Describe an approach for a program director (or other administrator) to take.
3. List specific things that should and should occur between a trainee and a supervisor.

When the Wheels Come off the Tracks

by Christopher Doty MD, FACEP, FAAEM

This is a disappointing story, but unfortunately is not unheard of. I'm aware of several real-life episodes of equally egregious behavior. Sexual harassment, which this vignette clearly is an example of, is one of the many forms of workplace aggression. In my opinion, sexual harassment is about dominance and control over another person. First and foremost, let us clearly establish that the orthopedic attending has acted in an absolutely unacceptable and probably illegal manner. I state this obvious point to amplify the fact that Samantha did not bring this behavior upon herself. Sometimes victims of sexual harassment begin to blame themselves for the unwanted attention or unacceptable behavior of their aggressors. Samantha has the reasonable expectation that her preceptors will act in a professional manner. Sexual harassment can be extraordinarily subtle or extraordinarily overt and anywhere in between. Early in her encounter, she even believes that she is imagining something that is not there. She identifies the feeling of the attending violating her personal space, but writes that off as her being too sensitive. The initial subtle invasion of space causes a gaslighting phenomena for Samantha. She temporarily questions her own perception and reality. "Is he getting too close? Am I just making this up?" This is a somewhat common initial experience for the victims of sexual harassment. The attending then becomes overt in his intentions. The questioning of her dating history is invasive, then the wheels come off the tracks and the interaction becomes criminal.

This should prompt Samantha to contact her faculty mentor or her Program Director immediately. These interactions are completely unacceptable in any employment situation, but are even more egregious when there is a preceptor-learner relationship. The power differential in a preceptor-learner relationship significantly worsens the learner's confidence in self-autonomy and ability to "push back". While it is reasonable for Samantha to directly deal with the orthopedic attending, it is rare that this actually happens because of the nature of the relationship and hierarchical structure seen in medicine. Residents undergoing these unacceptable interactions need to leverage their advocates and mentors. Faculty mentors and Program Directors should act as faculty advocates who can effectively deal with this situation in a way that the learner might not be ready to. Even though this is a preceptor-learner relationship, all universities and private institutions will have policies in place that explicitly forbid sexual harassment in the workplace. It is also covered under federal statute in Title 7 of the Civil Rights Act. While the student certainly should feel free to contact the responsible administrative officials at the institution, often it is more

reassuring to have faculty advocates initiate that process for them.

Program Directors should endeavor to have a relationship with their residents where the resident always feels the Program Director is their advocate, especially in situations where there is an imbalance of power. In the unfortunate situation where the Program Director does not immediately rectify this hostile work environment for the resident, the residents should move up the "food chain" immediately. The Designated Institutional Official (DIO), Associate Dean for Graduate Medical Education (GME), or director of the GME office should also be able to rectify this situation. The Human Resources office is also a good option. The Accreditation Council for Graduate Medical Education (ACGME) explicitly requires policies be in place for the institution to deal with sexual harassment. Furthermore, each program director has responsibility to maintain an educational environment conducive to educating residents. It is important for the resident to report this egregious behavior in order to prevent this behavior from being repeated. Bad behavior, if left uncorrected, has an excellent chance of being repeated. While a quick Internet search reveals many articles and blogs advising women that it is difficult to win a sexual harassment lawsuit, the same standards do not necessarily apply to universities and teaching institutions. Well governed by normal workplace law, and they're also governed by regulations through the ACGME and the sponsoring institution or university. Physically, I believe Samantha should leave the clinic immediately and approach a faculty advocate as soon as possible. The orthopedic attending has created a hostile and unsafe working environment and Samantha should not stay in proximity to the attending physician should this behavior be repeated or escalated.

I would like to reiterate that Samantha did not bring this behavior on herself. Clearly, since we are professionals, we have an obligation to dress professionally, act professionally, and interact with our colleagues professionally. However, even if Samantha had dressed more provocatively, this does not license the attending's behavior. Her previous relationship with a person that the attending knows does not license this behavior either. Samantha has a right to expect a safe, non-hostile, and professional work environment. Sexual advances should be left out of the workplace entirely and physicians in a supervisory role should remain extra vigilant regarding these issues. Sexual harassment is dominance over another person and is unacceptable under all circumstances.

As for Samantha's Program Director, I would recommend that he or she pursue the termination of the orthopedic attending

Expert Response

through the human relations or labor relations office for the institution or university. The orthopedic attending was inappropriate in both his words and actions and physically assaulted Samantha. There is no pathway back from those actions.

Other Resources Suggested by Dr. Doty

- [Sexual Harassment](#), U.S. Equal Employment Opportunity Commission website
- [Sexual Harassment - Legal Standards](#), Workplace Fairness website
- [ACGME Institutional Requirements](#) regarding required resident services (IV.H.3)
- [ACGME Common Program Requirements](#) regarding maintaining an educational environment



About the Expert

Christopher Doty (@PoppasPearls) received his MD from Thomas Jefferson University, Philadelphia and then completed his residency at Kings County Hospital /State University of New York. He was a faculty member at Kings County Hospital in the medical education division for 12 years and is now the Vice Chair and Residency Director in the Department of Emergency Medicine. He has won numerous institutional and national teaching awards and is also an Abraham Flexner Master Educator.

Legal Perspective on Sexual Harassment in the Workplace

by Cindy Caplan BCL, LLB

The case of the overly attentive attending presents a disturbing abuse of power and leaves the reader with a sense of dread about just how far things could have gone had the clinic nurse not interrupted the lecherous attending physician. But does the attending's conduct amount to unlawful sexual harassment? The highly unsatisfying answer is maybe.

Unlawful sexual harassment is a form of employment discrimination that violates Title VII of the Civil Rights Act of 1964 or similar state or local statutes. There are two common forms of sexual harassment. The first, known as quid pro quo harassment (roughly translated as "this for that"), occurs where a supervisor offers or denies benefits -- such as promotions desirable work assignments or raises -- in exchange for submission to unwelcome sexual conduct. The classic "you scratch my back and I'll scratch yours." The second, known as hostile environment sexual harassment, occurs when unwelcome conduct related to an employee's gender creates a working environment that is intimidating, hostile, or abusive. Examples of offensive conduct include unwanted sexual advances or contact; sexual comments, innuendoes or jokes, either directed at an employee or made in his or her presence; obscene or sexually oriented messages, such as inappropriate e-mails, videos or graphics on computer screens; comments involving demeaning sexual stereotypes; and remarks about an employee's anatomy. Unless extremely serious, isolated incidents will not generally rise to the level of unlawful sexual harassment. Rather, to be unlawful the conduct must be "pervasive."

The case presented here posits a single incident, albeit a very disturbing one. The fact that the attending physician physically touched Samantha and blocked her access to the door may be sufficient for a jury^[1] to consider the conduct "pervasive." In rendering an opinion, the jury would consider a number of other facts, including the attending physician's level of supervisory authority and whether he had been accused of prior incidents of harassment. Unfortunately, the jury would likely also consider

testimony related to Samantha's background and sexual history, and her relationship with the orthopedic resident would likely be raised as evidence to question her credibility.

But even if the attending's conduct does not amount to unlawful harassment, that does not mean Samantha has no recourse. She can, and should, make a formal complaint to her employer, whether that is the University or the hospital in which she works, so that neither she, nor her female colleagues, will be submitted to further instances of abuse. Employers generally have an anti-harassment policy that includes a complaint mechanism and a statement preventing retaliation against employees who make good faith complaints. When an employee does complain, the employer must promptly investigate the allegations and take appropriate remedial action to prevent further instances of harm. In this case, I would expect, at a minimum, for Samantha's employer to separate the two parties from further contact. He said/she said cases are difficult to substantiate but if, after thoroughly investigating the situation, additional instances of inappropriate behavior can be ascertained, the employer would likely take additional steps to discipline the physician, including possible termination. If the allegations cannot be substantiated, the employer should nonetheless warn that this conduct, if true, would be considered an egregious violation of their anti-harassment policy. They should also make it clear that they will be closely monitoring the attending physician going forward and that any steps on his part to make contact with Samantha will be dealt with in a serious manner. The employer's failure to take these important steps could lead them to be held liable if other instances involving this physician should occur.

Footnote

[1] Title VII dictates that when a complaining party seeks compensatory or punitive damages, any party may demand a trial by jury. 42 U.S.C. §1981a. Jury trials present a great deal of risk, which often leads the parties to settle cases out of court.



About the Expert

Cindy is an employment lawyer with over 15 years of experience defending discrimination and harassment complaints on behalf of her clients. She is presently a Cindy trains employers on how to avoid discrimination in the workplace and how to appropriately handle employee complaints should they arise. Cindy currently works in-house for Condé Nast magazines and its affiliated media entities. Prior to that Cindy served as in-house employment counsel at The Metropolitan Museum of Art.

Curated Community Commentary

By S. Lockett-Gatopoulos MSc, MD, FRCPC (candidate)

This month's case, *The Case of the Overly Attentive Attending*, follows Samantha, a junior emergency medicine resident, who has just begun her mandatory orthopedic surgery rotation. She has recently had a brief, casual romance with an orthopedic surgery resident, which ended amicably.

When Samantha begins her rotation, she experiences blatant and aggressive sexual advances from an attending physician who seems intimately aware of the details of her sexual relationship with the orthopedics resident. The interaction is interrupted when a nurse knocks on the door, terminating the unwelcome physical advances. Samantha leaves the orthopedics clinic in tears.

This commentary generated an animated discussion online as participants attempted to answer the question of what Samantha should do next, what steps should be taken once program directors or emergency staff were made aware of Samantha's situation, and whether legal action should be taken. Dr. Eve Purdy, an emergency medicine resident, opened the discussion with the acknowledgement that her 'exposure to a few, much more subtle, instances of sexual harassment make [her] well-aware that something as egregious as this case are within the realm of possible.' Both an anonymous contributor and attending physician, Dr. Loice Swisher, recounted episodes in their own careers that were not dissimilar to Samantha's experience, emphasizing that this is not an uncommon occurrence.

As to the question of what Samantha should do following the sexual assault, opinions were divided. Dr. Purdy and an anonymous contributor asserted that Samantha should leave clinic immediately. Dr. Purdy argued that Samantha 'would be putting herself at risk' and that 'her patients will not benefit from having a distracted physician'. Instead of staying in clinic, Dr. Purdy suggested that Samantha immediately 'go home and record the exact circumstances of the encounter while it is still fresh in her mind'. Similarly, our anonymous contributor asserted that Samantha was too distracted to care for patients and was personally unsafe while remaining in an environment where the attending physician might 'engineer' alone-time at the end of clinic.

On the other hand, Dr. Shahina Braganza, an Australian-based emergency physician, suggested that, while the default response might be that Samantha get out to take time to herself, she might instead strongly feel that she should return and complete her duties, and 'that would be okay, too'. All parties agreed that Samantha should seek out the guidance and counsel of a friend, mentor, family member, program director, family physician, or counsellor.

Regarding next steps, all participants agreed that the primary objective was protecting Samantha from further unwelcome

Contributors

Thanks to the participants (in alphabetical order) for all of their input:

Anonymous,
Shahina Braganza,
John Eicken,
Tamara McColl,
Eve Purdy,
Loice Swisher,
Alkarim Velji,
Richard van Wylick

advances. Dr. Purdy emphasized that 'immediate steps should be taken to ensure that [Samantha] does no clinic, on call, or [work in the OR] with this physicians,' with all other concerns being worked out after Samantha's immediate safety is established.

There was general agreement amongst participants that the residency program and program director play critical roles in supporting learners through experiences like the one Samantha has had. Dr. Braganza put it well, saying that the program director 'must balance advocacy for the junior doctor that is fair and just' and that the resident must be 'completely and unconditionally supported by an allocated team member' and 'protected personally and professionally' while also providing the senior physician with the opportunity to give his version of events.

Dr. van Wylick emphasized the critical importance of reporting the attending physician to regulatory authorities, as well as the hospitals and university with which he is associated. In his words, '[y]ou can bet that this is not the first time this physician has engaged in this type of behaviour, and it won't be the last without action'. Dr. Purdy agreed that Samantha should make a formal complaint to the university, the hospital, and the college or other regulatory body, but later tempered that statement with the realization that reporting might result in a 'tsunami' that would be 'a huge burden to ask Samantha to bear'. An anonymous contributor, in relating her story of inappropriate conduct by an attending physician, relayed her unwillingness to disclose the transgression due to the power imbalance and potential damage to her own career.

Emergency medicine resident Dr. Alkarim Velji pointed out that reporting might be difficult for Samantha as

Curated Community Commentary

residents 'are in the constant process of being interviewed for a job' and that 'that very mentality makes it challenging for advocates to address issues' with learner maltreatment. Dr. Braganza explained that in the Australian system options include a medical education unit that is established to oversee issues of learner wellbeing, acting as a neutral third party. Dr. Braganza suggested that legal action 'should be taken by the organization and not by an individual' and brought up the possibility of a peer support mechanism that might result in an informal dialogue, essentially resulting in the orthopaedic surgery attending 'being put on notice' as insurance against further transgressions.

Our discussion is perhaps best summed up with this astute observation by Dr. Purdy: 'I am certainly no expert, but it seems like if "aggressive" and "flirting" are in the same sentence you are probably doing it wrong'.

About

The Medical Education In Cases (MEiC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

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