

**University of New Mexico  
School of Medicine**

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**Department of Psychiatry**

**Geriatric Psychiatry Fellowship Training**

**Handbook  
2012-2013**





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**Overall Program Educational Goals 2012-2013**  
**Geriatric Psychiatry Fellowship**  
**University of New Mexico Health Sciences Center**

The Division of Geriatric Psychiatry conducts a comprehensive, well-balanced training program in geriatric psychiatry. This program is impacted by its own performance improvement practice, by historically honored principles of medical ethics, by societal expectations of physicians that they be altruistic, knowledgeable, skillful and dutiful (AAMC<sup>i</sup>), and by the requirements and recommendations of the American Council of Graduate Medical Education and the Fellowship Review Committee in Psychiatry. In keeping with ACGME and RRC mandates this program follows core competencies in the six required areas and requires its fellows to develop these competencies to the level of a new practitioner over the period of the two year training program in child and adolescent psychiatry. The six required areas are:

- 1) patient care
- 2) medical knowledge
- 3) practice-based learning and improvement
- 4) interpersonal and communication skills
- 5) professionalism
- 6) systems-based practice.

**PATIENT CARE**

Fellows must be able to provide patient care that is compassionate, appropriate, culturally responsive and effective for the treatment of elder adult mental health problems, and for the promotion of health.

Fellows shall demonstrate the ability to perform, present, and document a comprehensive psychiatric examination of culturally diverse elder adult patients, to include:

- Complete present and past psychiatric history
- Sociocultural and educational history
- Family history, including ethnocultural and generational aspects
- Medical history and review of systems
- Developmental history
- History of trauma/abuse
- Substance abuse/exposure history
- Mental status examination including the assessment of cognitive functioning
- Physical and neurological examination

Based on a comprehensive psychiatric evaluation, fellows shall demonstrate the ability to develop and document:

- Complete DSM IV-TR multiaxial differential diagnosis
- Case formulation that includes neurobiological, psychological, and sociocultural issues involved in diagnosis and management
- Evaluation plan, including appropriate laboratory, medical, and psychological examinations
- Treatment plan, addressing the bio/psycho/social domains and including awareness of and appropriate use of medical and mental health resources

Fellows shall demonstrate the ability to assess, discuss, and document the patient's potential for harm to self or others, and the ability to intervene effectively. This shall include:

- Risk assessment
- Knowledge of involuntary treatment standards and procedures for elder adults in the state of New Mexico
- Effective interventions to minimize risk
- Implementation of prevention methods for self harm and harm to others

Fellows shall demonstrate the ability to conduct therapeutic interviews and to carry out exploratory interventions and clarifications.

Fellows shall demonstrate beginning skills in major psychotherapy treatment modalities including brief and long term individual therapy, family therapy, group therapy, crisis intervention, supportive therapy, psychodynamic psychotherapy, behavior therapy, cognitive-behavioral therapy, dialectical behavior therapy, and pharmacotherapy.

#### **MEDICAL KNOWLEDGE**

Fellows must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and sociobehavioral) sciences and the application of this knowledge to patient care.

Fellows are expected to demonstrate knowledge of the major psychiatric disorders, including age, gender, and sociocultural considerations, based on the scientific literature and standards of practice. This knowledge shall include:

- DSM IV-TR diagnostic criteria
- Epidemiology, etiology, phenomenology, course and prognosis of the disorder
- Effective treatment strategies
- Experience, meaning, and explanation of the illness for the patient and family

Fellows shall demonstrate knowledge of psychotropic medications as applied to the treatment of elder adults. This knowledge shall include:

- Pharmacological action and pharmacokinetics
- Approved clinical indications and "off label" use in elder adults
- Age, gender and ethnocultural variations
- Side effects, toxicity, drug interactions
- Evidence based medicine data base for use of psychotropic medications in elder adults

Fellows shall demonstrate knowledge of human aging and development, including theories and principles of typical and atypical development.

Fellows shall demonstrate knowledge of emergency psychiatry, to include:

- Suicide
- Crisis intervention
- Differential diagnosis and management in emergency situations

- Homicide, sexual assault, violent behavior, elder abuse

Fellows shall demonstrate knowledge of substances of abuse, including:

- Epidemiology, including sociocultural factors
- Diagnosis and treatment of substance intoxication, overdose, withdrawal, abuse, and dependence, in elder adults

Fellows shall demonstrate knowledge of behavioral science and sociocultural psychiatry, including:

- Theories of normal family organization, dynamics, and communication
- Theories of group dynamics and process
- Epidemiology
- Research methods and statistics
- Cross cultural psychiatry

Fellows shall demonstrate conceptual understanding of major treatment modalities including brief and long term individual therapy, family therapy, group therapy, crisis intervention, supportive therapy, psychodynamic psychotherapy, behavior therapy, cognitive-behavioral therapy, dialectical behavior therapy, pharmacotherapy, and electroconvulsive therapy.

Fellows shall demonstrate knowledge of patient evaluation and treatment selection, including:

- Psychological and neuropsychological testing
- Laboratory and neuroimaging methods used in geriatric psychiatry
- Diagnostic interviewing including mental status examination
- Treatment comparison and selection

Fellows shall demonstrate knowledge of consultation psychiatry to include:

- Models of consultation psychiatry
- Consultation to geriatrics, including geriatric subspecialties
- Consultation to the elder care facilities (nursing home)
- Consultation to community systems of care
- Psychosomatic and somatopsychic disorders
- Psychiatric aspects of nonpsychiatric illness
- Specific syndromes

Fellows shall demonstrate knowledge in forensic psychiatry, including legal issues relevant to geriatric psychiatry

Fellows shall demonstrate knowledge of medical ethics as applied to psychiatric treatment of elder adults.

Fellows shall demonstrate knowledge of administrative psychiatry and systems of healthcare delivery.

## **PRACTICE-BASED LEARNING AND IMPROVEMENT**

Fellows must be able to expand their knowledge and skills based on an assessment of need when comparing their practice to best practices. In support of this they must investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices on an ongoing basis. Fellows are expected to:

- Understand the need for lifelong learning.
- Understand and demonstrate the ability to obtain up-to-date information from the scientific literature to assist in the quality care of patients, and to critically evaluate this literature.
- Analyze practice experience and perform practice-based improvement activities using a systematic methodology
- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- Use information technology to manage information, access on-line medical information; and support their own education
- Facilitate the learning of students and other health care professionals
- Evaluate their caseloads and practice experience in a systematic manner and develop and pursue effective remediation strategies based on critical review of the scientific literature.

## **INTERPERSONAL AND COMMUNICATION SKILLS**

Fellows must be able to demonstrate interpersonal and communication skills that result in effective and empathic information exchange, clinical work and decision making with patients, patients' families, and professional associates. Fellows shall demonstrate the ability to:

- Communicate effectively with patients and families, allied healthcare professionals, and with other professionals using verbal, nonverbal, and writing skills as appropriate
- Foster a therapeutic alliance with their patients and patients' families
- Transmit information to patients and families in a clear, meaningful fashion
- Understand the impact of their own feelings and behavior on psychiatric treatment and to manage their own affects and counter transference
- Educate patients, families, and other professionals about medical, psychological, and behavioral issues
- Work effectively within multidisciplinary teams as member, consultant, or leader
- Elicit information
- Obtain, interpret, and evaluate consultations from other medical specialties, other helping professionals, and community based resources
- Serve as effective consultants to other professionals and community based resources
- Maintain timely, legible, and complete psychiatric medical records

## **PROFESSIONALISM**

Fellows must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, sensitivity to a diverse patient population, and commitment to professional excellence.

Fellows will be expected to demonstrate:

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- Commitment to ethical principles pertaining to clinical care, confidentiality, informed consent and assent, involuntary treatment, and business practices including interactions with pharmaceutical companies
- Sensitivity and responsiveness to patients' culture, age, gender, and disabilities
- Responsibility for their patients' care including responding to patients' communications, providing appropriate documentation, coordinating care, and ensuring continuity of care

## **SYSTEMS-BASED PRACTICE**

Fellows must demonstrate an awareness of, and skill in working within the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Fellows will be able to:

- Know the resources available both publicly and privately for the treatment of psychiatric/behavioral /medical problems
- Use these systems of care in the treatment of their patients
- Coordinate clinical interventions with other disciplines or transition of care
- Demonstrate the ability to work within a managed care system and understand the role of insurance companies, Medicare and Medicaid
- Demonstrate knowledge of community systems of care and assist their patients to access appropriate psychiatric care and other mental health support services
- Demonstrate knowledge of and interact with social services system
- Utilize clinical information systems, including electronic medical records, order entry systems and scheduling systems

**GRADUATE EDUCATION COMMITTEES**  
**DEPARTMENT OF PSYCHIATRY**  
**UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE**

We offer graduate education in psychiatry to qualified trainees. All programs are under the general direction of the Chairman of the Department of Psychiatry with the advice of the Residency Training Committee and the Residency Steering Committee.

**RESIDENCY TRAINING COMMITTEE (RTC)**

The Fellowship Program at the University of New Mexico Psychiatric Center and the Albuquerque Veterans Administration Medical Center is administered by the Director of Residency Training and the Residency Training Committee and its various subcommittees. This committee formulates educational policy, oversees the curriculum formulated and evaluated by the curriculum subcommittee, serves as the fellowship selection committee and the quality assurance committee, and monitors the overall progress of the fellows' performance and competence. In the latter capacity this committee assesses fellows' progress including suitability for promotion and graduation, and formulates plans for remediation and administrative action for fellows whose performance needs improvement. The Director, with input from the Residency Training Committee, ensures coordinated fellowship education within the facilities. The Residency Training Committee serves as the body to review special requests from fellows such as moonlighting and leave. The Committee also serves as the review board in cases of grievances and performance problems. The Committee reports to the Vice Chairs and Chairman of the Department.

The Residency Training Committee meets the first and third Tuesdays of each month from 12:00 to 1:00 PM in the Department of Psychiatry in Room 410. Meetings are open to any member of the fellowship group or faculty unless confidential material is to be discussed.

**PROFESSIONALISM AND PROMOTIONS SUB-COMMITTEE**

This is a sub-committee of the Residency Training Committee responsible for recommendations for promotion of residents and fellows from year to year. The committee meets at least quarterly to review information that is pertinent to fellow performance. The task of the committee is to review issues of administrative competence and professionalism. This in conjunction with reviews of performance on clinical rotations, performance on required evaluative measures each year, and recommendations from the Fellowship Training Director, which will all be considered by the RTC at large for recommendations for promotion at the end of each calendar year. If there is any concern about the performance of a fellow during the year, the fellowship training director will provide this feedback to the fellow.

This Professionalism and Promotion Committee will be composed of three members of the larger Residency Training Committee who are leaders in both the clinical and education realms of the department. The committee will review information including but not limited to the following:

Didactic attendance

Timely and complete requests for leave  
Reports of unprofessional conduct  
Adherence to issues as delineated in the fellow handbook

**RESIDENCY TRAINING COMMITTEE  
2012 - 2013**

Chair: Training Director, Stephen Lewis, M.D.,  
Executive Medical Director University Psychiatric Center, William Apfeldorf, MD, PhD,  
Director, Addiction Psychiatry Fellowship, Pat Abbott, MD,  
Director, Child and Adolescent Psychiatry Fellowship, Jeanne Bereiter, MD  
Geriatric Psychiatry Fellowship, Aaron Brodsky, MD  
Associate Training Director, Rural and Community Programs, Caroline Bonham, MD  
Associate Training Director, VA Medical Center, Carl Brown, MD  
Associate Training Director, UNM PC, Pam Arenella, MD  
Representative Director, UNM PC Outpatient Clinic, Elizabeth Weil, M.D.,  
UPC Inpatient Services, Director Psychosomatics Fellowship, Gray Clarke, MD  
Medical Director, Inpatient Psychiatry, VA Medical Center, Rob Coberly, MD,  
Former Residency Training Director, E.H. Uhlenhuth, MD  
Director Medical Student Education, Debbie Dellmore, MD  
Vice Chairman for Education and Academic Affairs, Jeff Katzman, MD  
Medical Director, Outpatient Services UNM PC, Mario Cruz, MD  
Resident Representatives:  
    Chief Resident, UNM PC outpatient services, Paul Romo, MD  
    Chief Resident, UNM PC inpatient services, Gabriella Prieto, MD  
    Chief Resident, VAMC, Melissa Merhege, MD  
    President, Resident Congress Committee, Caitlin Dufault, MD

Additionally, the Residency Training Committee can form sub-committees as necessary to address complex problems that arise during the course of the academic year.

**FACULTY**  
**UNIVERSITY OF NEW MEXICO**  
**DEPARTMENT OF PSYCHIATRY**  
**GERIATRIC PSYCHIATRY FELLOWSHIP**  
**H. George Nurnberg, M.D., Interim Chairman**

**Core Teaching Faculty:**

Christopher Abbott, M.D., Assistant Professor  
Department of Psychiatry  
Medical Director, Geriatric Outpatient Services  
Attending Psychiatrist: University Psychiatric Center Seniors Clinic  
Areas of Specialization: Geriatric Psychiatry, research, neuroimaging

William Apfeldorf, M.D., Ph.D., Professor  
Department of Psychiatry  
Vice Chair for Clinical Services  
Medical Director of UNM Psychiatric Center  
Training Director, Geriatric Psychiatry Fellowship Program  
Attending Psychiatrist: UNM Psychiatric Center Inpatient Geriatric Unit  
Areas of Specialization: Adult and geriatric psychiatry, psychopharmacology

Aaron Brodsky, M.D., Assistant Professor  
Department of Psychiatry  
Attending Psychiatrist: University Psychiatric Center Inpatient Geriatric Unit and Geriatric  
Psychiatry Outpatient Clinics  
Areas of Specialization: Inpatient geriatric psychiatry, academic and administrative psychiatry

Christina Trevino, MD, Assistant Professor  
Department of Psychiatry, VA Medical Center  
Associate Geriatric Psychiatry Fellowship Training Director, VAMC  
Areas of Specialization: Geriatric cognitive disorders, late life psychosis, schizophrenia

Cynthia Geppert, M.D., M.A., Ph.D., Associate Professor  
Attending Psychiatrist, Veterans Administration Medical Center  
Areas of Specialization: clinical ethics

**Associated University of New Mexico Faculty:**

Swala Abrams, MD, Assistant Professor  
Department of Psychiatry  
Areas of Specialization: Care of the marginalized patient, psychosocial factors in treatment  
resistance, medical co-morbidity and chronic mental illness, ECT, resident education

John Adair, MD, Assistant Professor

Department of Neurology

Kathleen Haaland, PhD, Professor

Department of Psychiatry

Areas of Specialization: Neuroanatomical correlates of complex movement by studying cognitive-behavioral deficits in focal lesion stroke and Parkinson's and Huntington's Disease and functional MRI; ipsilesional motor deficits after stroke and its functional implications; cognitive changes with normal aging.

Donna Parker, MD Assistant Professor

Department of Internal Medicine, Division of Geriatrics

Davin Quinn, M.D. Assistant Professor

Department of Psychiatry

Director of Consultation and Liaison Psychiatry Service

Attending Psychiatrist, UNMPC

Areas of Specialization and Interest: Psychosomatic medicine and consultation psychiatry; Traumatic brain injury, delirium, neurodegenerative disorders, epilepsy psychiatry; Bone marrow transplant psychiatry, psycho-oncology; Psychodynamic psychotherapy

Joseph R. Sadek, Ph.D., Assistant Professor

Department of Psychiatry

Supervisor, Neuropsychological Assessment

Areas of Specialization: Neuropsychology, Alzheimer's disease, Vascular Dementia, Stroke, Everyday Functioning, Schizophrenia

Rex Swanda PhD, Professor, Volunteer Faculty

Department of Psychiatry, Department of Psychology

April Volk, MD, Assistant Professor

Department of Internal Medicine, Division of Geriatrics

**Associated VA Medical Center Faculty:**

Howard Berger, MD Volunteer Faculty

Clinical Assistant Professor

Psychiatrist, VA Medical Center

John Carty, MD Volunteer Faculty

Psychiatrist, VA Medical Center

Soofia Khan, MD Volunteer Faculty

Acting Clinical Chief, Stroke and rehabilitation service, VA Medical Center

Board Certified in Rehabilitation Medicine

Board Eligible in Spinal Cord Injury Medicine

Corbett Schimming, MD, Assistant Professor  
 Attending geriatric psychiatrist, VA

Virginia Porterfield, MD, Assistant Professor (pending promotion to Associate Professor)  
 Veterans Administration Medical Center Psychiatry, Outpatient Clinic  
 Areas of Specialization: general psychiatry, ECT

**PART I – CORE TRAINING EXPERIENCES**

**CORE TRAINING EXPERIENCES**  
**INPATIENT GERIATRIC PSYCHIATRY ROTATION**

*Abbreviations:*

- |   |                         |
|---|-------------------------|
| PC – Patient Care                             | CC – Case Conference    |
| MK – Medical Knowledge                        | QZ – Quiz               |
| PBL – Practice Based Learning and Improvement | TR – Teaching Rounds    |
| ICS– Interpersonal and Communication Skills   | FB – Feedback           |
| PROF – Professionalism                        | DM – Demonstration      |
| SBP – Systems-Based Practice                  | LC – Lecture            |
|   | AR – Assigned Reading   |
|   | DO – Direct Observation |

**EDUCATIONAL OBJECTIVES:**

<b>At the end of the rotation the fellows in addition to all the objectives of the general unit will have:</b>	<b>Competencies Addressed</b>
Functioned as the primary physician and as the team leader for patients in a geriatric psychiatry inpatient unit, under supervision of the attending physician.	MK, PC, ICS, PROF
Received direct training in the neurological, mental status and cognitive exams.	MK, PC
Completed a work up, formulation and follow the care of 14 to 20 patients over the duration of the rotation. Including medical, laboratory, and imaging studies.	MK, PC, PBL
Participated in assessing needs and services for aging adults relevant to the practice of inpatient geriatric psychiatry, through personal effort and appropriate referral.	MK, PBL, SBP
Managed medications for all patients including psychopharmacology.	MK, PC, PBL
Worked with consulting primary care practitioners and medical specialists.	MK, ICS, SBP
Consulted with social work, nursing, and other health care workers.	ICS, SBP, PROF
Worked with ten or more patients with dementias/cognitive impairments.	MK, PC
Through teaching rounds and case conferences, mental status, dementias and other topics are reviewed.	MK, PBL, ICS, PROF, SPB
Manage the unit to include both treatment teams, including control of census, residents and medical student supervision and education.	

Supervise didactics for both residents and medical students.	
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**INPATIENT EXPERIENCE EDUCATIONAL GOALS:**

<b>Fellows will learn to:</b>	<b>Competencies Addressed</b>	<b>Clinical Teaching Methods</b>	<b>Didactic Experience</b>	<b>How Assessed</b>
Develop clinical and scholarly familiarity with the more common forms of psychopathology such as schizophrenia, affective disorders, personality disorders, substance abuse disorders, dementia, delirium and others.	MK, PBL	CC, TR DM	LC, AR	DO, QZ FB
Become proficient with the use of therapeutic modalities currently used in inpatient psychiatry especially psychopharmacological agents.	MK, ICS, PC	CC, TR, DM	LC, AR	DO, QZ FB
Conduct the assessment and the management of acute adult psychiatry patient on an inpatient unit.	ICS, SBP, PC, PROF	CC, TR, DM	LC, AR	DO, FB
Develop good interviewing skills that establish patient rapport.	ICS, PC, PROF	CC, TR, DM	LC, AR	DO, FB
Develop good history taking and mental status examination skills leading to an adequate differential diagnosis.	MK, ICS, PC	TR,DM	LC, AR	DO, FB
Establish the skills of good medical record keeping including present illness, history, physical examination, progress notes, correspondence, and discharge summaries.	ICS, MK, SBP, PROF	TR, DM	LC, AR	DO, FB
Write orders for the management of psychiatric and medical conditions.	ICS, SBP	TR, DM	LC	DO, FB
Develop basic knowledge and skills of supportive psychotherapy with chronically mentally ill patients.	MK, ICS, PBL	DM	LC, AR	DO, FB

**CORE TRAINING EXPERIENCES:**  
**OUTPATIENT SENIOR'S CLINIC**

The University of New Mexico Mental Health Center Seniors' Clinic panel includes approximately 375 patients with major depression, bipolar disorder, schizophrenia, anxiety disorders, chemical dependency and dementia with behavioral disturbance. The Seniors Clinic evaluates over 20 new patient visits every month. Patients are referred from their primary care physicians, inpatient psychiatric units, and community residential facilities. The psychiatrist can work as a consultant with the primary physician or can manage the more complicated patient for a longer period of time. The focus of Seniors Clinic is a multi-disciplinary team approach incorporating nursing, case management, and neuropsychologists.

This required 12-month rotation (minimum ½ day per week) is designed to train the geriatric psychiatry fellow in the management of the senior psychiatric patient. The fellow will become an expert on cognitive screening and the diagnosis and treatment of the dementias. The fellow will also become adept at recognizing psychotropic medications contra-indicated in the elderly and will safely transition these patients to a safer but equally efficacious medication regimen. Attending physicians include Chris Abbott, MD; Aaron Brodsky, MD; and William Apfeldorf, MD, PhD.

PC – Patient Care

MK – Medical Knowledge

PBL – Practice Based Learning and Improvement

ICS – Interpersonal and Communication Skills

PROF – Professionalism

SBP – Systems-Based Practice

**EDUCATIONAL GOALS:**

<b>Fellows will learn to:</b>	<b><u>Competencies Addressed</u></b>
The fellow will, with limited supervision, manage ethnically and socioeconomically diverse panel of geriatric patients, with a broad range of medical, functional, and psychosocial problems, in an outpatient setting	PC, MK, PBL, ICS, PROF, SBP
Become expert in efficient use of cognitive screening in a routine new patient visit and follow up visit.	MK, PC, PROF
Lead a multidisciplinary team, physicians, nurse practitioners, pharmacists, case manager and social worker), dietitian, physical or occupational therapist, and psychologists	PC, PBL, ICS, PROF, SBP
Use cognitive assessments to recognize neurodegenerative disorders	MK, PC, PBLI
Identify appropriate patients for neuropsychological testing referral	SBP, PBLI, PC, MK
Become knowledgeable at understanding the pathophysiology and clinical presentation of the common dementias. The fellow will also become an expert in the diagnosis and treatment of Alzheimer's disease, vascular dementia, and fronto-temporal dementia	MK, PC, PBLI
Become adept at appropriately referring patients to neuropsychology, occupational therapy, and case management	MK, PC, PBLI

Gain expertise working as a consultant with the primary care physician	PC, SBP
Gain expertise starting, titrating and discontinuing psychotropic medications in the elderly	MK, PC

**EDUCATIONAL OBJECTIVES:**

<b>By the end of the rotation, Fellows will have:</b>	<b><u>Categories</u></b>
Become expert at comprehensive assessment of geriatric patients. Assessments will include standard instruments for cognitive screening and evaluation of patients' care and home situations as aids or impediments to effective care	MK, PC, PBLI
Completed and interpreted cognitive assessments during routine clinic appointments	PC, MK, SBP
Appropriately diagnose the type of dementia based on cognitive screening, neuro-imaging, and collateral information	MK, PC, PBLI
Gained experience in discussing advance directives with patients	PC, ICS, PROF, SBP
Appropriately refer patients to members of the multi-disciplinary team that include neuropsychology, occupational therapy, and case management	SBP, PC, PROF
Appropriately ordered tests and therapies as the patient nears the end of life. Fellows will engage care-givers and patients in these decisions in a collaborative fashion	PC, MK, ICS, PROF
Safely started and titrated the appropriate psychiatric medication for the disorder. The fellow will also become proficient at using augmentation strategies in the treatment-resistant patient	MK, PC, PBLI

**CORE TRAINING EXPERIENCES:**  
**MANZANO DEL SOL/NURSING HOME ROTATION**

The Manzano del Sol Village Good Samaritan Society nursing home rotation allows fellows to express their training in a community setting. The Good Samaritan Society – Manzano del Sol Village is a proud provider of senior living apartments as well as a full-service healthcare center. In addition to skilled and intermediate care, Manzano del Sol Village's healthcare center offers specialized care for people with dementia and Alzheimer's disease. Fellows function as psychiatric consults to patients with dementia and delirium. Clinical Supervision is provided by Aaron Brodsky, MD.

PC – Patient Care  
 MK – Medical Knowledge  
 PBL – Practice Based Learning and Improvement  
 ICS – Interpersonal and Communication Skills  
 PROF – Professionalism  
 SBP – Systems-Based Practice

**EDUCATIONAL GOALS:**

<b>Fellows will learn to:</b>	<b>Competencies Addressed</b>
Become knowledgeable and proficient in gathering components of a dementia history.	MK, PC
Become proficient in the treatment of dementia with behavior disturbance.	MK, PC
Develop an understanding of the impact that psychiatric and medical disorders have on one another in elder adults.	MK, PC, PBLI
Become knowledgeable about the signs and symptoms of delirium and be able to readily coordinate appropriate treatment.	MK, PC
Develop an understanding of the role that medication, therapy and community support have in the treatment of geropsychiatric disorders.	MK, PC, SBP

**EDUCATIONAL OBJECTIVES:**

<b>By the end of training, fellows will have:</b>	<b>Competencies Addressed</b>
Managed the treatment of patients with geropsychiatric disorders with sensitivity to using the Beer’s criteria.	PC, MK
Developed knowledge of the interplay of social, cultural, psychological, spiritual, familial, and biological factors affecting the patient and patient management.	MK, PC, ICS, SBP
Functioned as psychiatric consultant to other physicians in the nursing home setting.	SBP, PROF, PBLI, ICS, PC, MK
Performed a literature review of a topic in geropsychiatry and provided evidential presentation and discussion to faculty.	MK, ICS

**CORE TRAINING EXPERIENCES:**  
**VETERAN’S ADMINISTRATION (VA) PHYSICAL MEDICINE & REHABILITATION**  
**ROTATION**

Rehabilitation medicine program is a comprehensive inpatient and outpatient service that provides comprehensive, interdisciplinary rehabilitation to veterans with complex medical/ neuromuscular/ orthopedic conditions including amputations, stroke and traumatic brain injury. Incorporate rehabilitation in patient management.

This outpatient/ inpatient Rehabilitation medicine rotation is designed to train fellows in the comprehensive evaluation and management of patients in the rehabilitation setting. The fellow will serve as a rehabilitation consultant and participate in comprehensive medical evaluations on veterans.

**Objectives of the Consultation Service:**

- 1- Performance of appropriate history and physical examination focusing on impairment, disability, and other functional aspects of the patient.
- 2- Development of skills required to manage a large consultative service in a tertiary care hospital setting.
- 3- Development and implementation of appropriate therapeutic protocols and plans, including interdisciplinary care, durable medical equipment, and further diagnostic and therapeutic options as indicated.
- 4- Demonstration of ability to present cogent case histories to the attending physician in charge of the consult service
- 5- Application of appropriate selection and screening criteria to determine appropriate level of rehabilitative care and familiarity with all options.

Fellows will function as part of a multidisciplinary treatment team. Attending physician: Soofia Khan, MD, Board Certified in Rehabilitation Medicine (Acting Clinical Chief, Stroke and rehabilitation service), BE in Spinal Cord Injury Medicine. The multidisciplinary team includes physicians, social workers, and registered nurses, Therapists (Physical, Occupational, Speech, language pathologist, rehabilitation specialist, and Clinical Pharmacist.

*Abbreviations:*

- |   |                            |
|---|----------------------------|
| PC – Patient Care                             | CC – Case Conference       |
| MK – Medical Knowledge                        | QZ – Quiz                  |
| PBL – Practice Based Learning and Improvement | TR – Teaching Rounds       |
| ICS– Interpersonal and Communication Skills   | FB – Feedback              |
| PROF – Professionalism                        | DM – Demonstration         |
| SBP – Systems-Based Practice                  | DS– Didactic Seminar       |
|   | AR – Assigned Reading      |
|   | DO – Direct Observation    |
|   | IS- Individual Supervision |
|   | JC-Journal Club            |

**EDUCATIONAL GOALS:**

Fellows Will:	Competencies	Clinical	Didactic	How
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	<b>Addressed</b>	<b>Teaching Methods</b>	<b>Experience</b>	<b>Assessed</b>
<p>1. Cite and apply outcome-based criteria for determination of candidacy for admission to acute inpatient unit</p> <p>Apply current knowledge in rehabilitation medicine to the design and implementation of goal-based, therapeutic protocols for inpatients.</p>	PROF, ICS, PBLI	DM, TR, CS  TR AR Interdisciplinary Team Conference		DO, FB Chart evaluations
<p>2. Write detailed, comprehensive prescriptions for durable medical equipment, including ambulatory assistive devices, prosthetics, orthotics, and wheelchairs evaluations.</p>	SBP	DM, One on one, case by case teaching in clinics with MD, Prosthetist and Physical therapist		DO Chart evaluation of documentation skills
<p>3. Function as part of an interdisciplinary rehabilitation team.</p>	MK, PROF	Comprehensive evaluations including functional assessment		DO, FB
<p>4. Cite and apply objective tools of measurement for patients with disability to measure changes in functional status.</p>	PC, MK	TR, CS	TR	DO, FB
<p>5. Attain competency and expertise in the management of emergent, complicating conditions affecting inpatients on the rehabilitation unit Patient management of complications, falls, wounds and acute medical events.</p>	PC, MK, PBLI	DM, CS		DO, FB

**EDUCATIONAL OBJECTIVES:**

<b>By the completion of the rotation, each fellow will have:</b>	<b>Competencies Addressed</b>	<b>Clinical Teaching Methods</b>	<b>Didactic Experience</b>	<b>How Assessed</b>
1. Performed rehabilitation consultations on veterans referred by primary care and other specialty services in VA hospital and Community based clinics.	PBLI, ICS, MK, PROF	DM, CS, AR,	JC	DO, FB
2. Attended and participated in weekly multidisciplinary team meetings	MK, ICS	CC	CC	DO, FB
3. Attain competency and expertise in diagnostic evaluation of patients with neuromuscular, musculoskeletal, cardiopulmonary, rheumatologic, or other disabling conditions.	PROF, PBLI, PC	DS, AR		FB
4. Cite alternative methods and systems for delivery of rehabilitative services, i.e., sub-acute-short-term, long-term, home care, etc	MK	AR		DO, FB Comprehensive evaluations including functional assessment, Physical Therapists, Occupational and speech therapists
5. Development and implementation of appropriate therapeutic protocols and plans, including interdisciplinary care, durable medical equipment, Prosthetics and Orthotics and further diagnostic and therapeutic options as indicated.	PROF, PBLI, ICS	CS Case management, discussion		DO, FB

**CORE TRAINING EXPERIENCES:**

**CONSULTATION LIAISON PSYCHIATRY ROTATION**

This is a required 12-month, 10%. Patients are seen at University Hospital or the Veteran’s Administration Hospital. The medical director of this service at both locations is a full-time department of psychiatry faculty member

As well, the fellow interacts with a broad range of medicine and geriatric medicine specialty faculty.

The Consultation/Liaison (C/L) Service provides psychiatric evaluations, crisis intervention and psychiatric follow-up (short-term psychotherapy, monitoring of psychiatric medication, and family support) to adults over the age of 65. Participation in patient care conferences, teaching, and meeting with medical and nursing staff are other services routinely provided.

The fellow consults with the patient’s primary treatment team regarding psychiatric issues, with close collaboration and supervision by the C&L Medical Director. The fellow receives individual supervision on each consultation, averaging two hours per patient and usually including attendings’ participation in the fellow’s diagnostic interview and evaluation of the patient.

The fellow performs comprehensive psychiatric evaluations of older adult’s family members. In addition to providing psychiatric expertise to the medical staff caring for the older adult, the fellow works closely with geriatric medicine, nursing, and other staff in the management of the adults for whom they are consulted. Following the initial evaluation, the fellow provides short-term supportive crisis intervention, works with family members of injured or other medically ill older adults, as well as psychopharmacotherapy for depression, anxiety, pain or agitation. The older adults seen in consultation represent various cultures and ethnic backgrounds but in particular are Caucasian, Native American (Pueblo and Navajo) or from various Hispanic cultures. An average caseload for a fellow is three to five new consults per week and ten to fifteen follow-up visits to older adults and their families per week. Clinical Supervisor is Davin Quinn, MD.

*Abbreviations:*

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|---|----------------------------|
| PC – Patient Care                             | CC – Case Conference       |
| MK – Medical Knowledge                        | QZ – Quiz                  |
| PBL – Practice Based Learning and Improvement | TR – Teaching Rounds       |
| ICS– Interpersonal and Communication Skills   | FB – Feedback              |
| PROF – Professionalism                        | DM – Demonstration         |
| SBP – Systems-Based Practice                  | DS– Didactic Seminar       |
|   | AR – Assigned Reading      |
|   | DO – Direct Observation    |
|   | IS- Individual Supervision |

<b>Fellow will learn to:</b>	<b>Competencies Addressed</b>	<b>Clinical Experience</b>	<b>Didactic Experience</b>	<b>Assessment Method</b>
Develop and consolidate the knowledge, attitudes, and skills	MK, PBL	TR, DM	DS, AR	DO, FB

necessary for the psychiatric evaluation of patients in medical and surgical settings.				
Function as a psychiatric consultant to other physicians in settings ranging from primary care to specialized units; to communicate promptly, clearly, and to formulate a useful, goal-directed, problem-oriented treatment plan and to utilize system resources	PC, MK, PBL, ICS, PROF, SBP	TR, DM,	CC, AR,	DO, FB
Develop awareness and the facility to appraise existing scientific evidence, future research possibilities and empirically based practice patterns of consultation-liaison psychiatry and abilities to evaluate and improve their own patient care.	PB, PBL	TR	DS, AR	DS,CC
Take into account the interplay of social, cultural, psychological, spiritual and biological factors effecting patient and patient management	PC, MK, PBL	CC, TR, DM	DS, AR	DS,CC,FB
Help primary medical teams to care for complex patients effectively and with compassion, empathy, respect, sensitivity, responsibility and professionalism.	PC, SBP, ICS, PROF	TR, DM	DS, DM	DO, FB
Diagnose, evaluate and treat the psychiatric manifestations of medical illnesses, manage psychiatric disorders presenting with somatic symptoms, and work therapeutically with patients with psychosomatic or stress-related illnesses or patients suffering from psychological consequences of illness and injury.	PC, MK, PBL	TR, DM	DS, AR,CC	DO, FB,CC
Acquire the knowledge and skills of data gathering, case formulation and intervention as	PC, MK, ICS, SBP	TR, DM	LC	DO, FB

a consultant in medical settings.				
Function as teachers of the principles and practice of psychosomatic medicine to other health-care workers and to provide medical student training and leadership by modeling interviewing skills and professional demeanor toward patients; and to assist students in preparing for their future roles in patient care.	PROF, SBP, ICS	DM	LC, AR	DO, FB
Develop the knowledge and skills necessary to perform sound assessments of cognitive ability and decisional capacity in medically ill patients and to identify, and address ethical issues involved in patient care according to established ethical principles and with sensitivity to culturally diverse populations and their values team.	MK, PC, PBL, PROF	TR, DM	AR, DS	DO, FB

**EDUCATIONAL OBJECTIVES:**

<b>Fellows will be able to</b>	<b>Competencies Addressed</b>	<b>Clinical Experience</b>	<b>Didactic Experience</b>	<b>Assessment Methods</b>
Demonstrate skill in the evaluation and diagnosis of psychiatric disorders, relevant medical conditions, stress response syndromes, subtle brain injury or degeneration syndromes, conversion reactions, pain, decisional capacity for informed, and disposition, dangerousness, including suicide, homicide and self injury and the ability to leave the hospital against medical advice.	PC, MK, PBL	TR,CC, DM	AR,DS,CC	FB,DO

The ability to write a clear, succinct consultation report which answers the questions posed and provides information necessary to support recommendations and is realistic within the system of health care and larger social context in which the patient is being treated.	PC, MK, ICS, SBP	DM	AR	FB,IS
Ability to provide brief, focused psychotherapy, behavioral management techniques, family therapy, and psycho-education for medical/surgical patients.	PC, ICS	DM,TR	AR,DS	IS
Ability to use psychotropic medications in medical/surgical patients, and appreciate physiological effects, contraindications, drug interactions, and dosing concerns.	PC, MK, PBL	DM,TR	AS,DS	FB,DO

**CORE TRAINING EXPERIENCES:**  
**RESEARCH ELECTIVE ROTATION**

The University of New Mexico Geriatric Psychiatry Research is focused on neuroimaging of older patients with schizophrenia and mood disorders. The imaging modalities include functional magnetic resonance imaging, structural magnetic resonance imaging, diffusion tensor imaging, proton spectroscopy, and magneto-encephalography. Data analysis methods include the general linear model and data-driven methods such as independent component analysis. Current investigations include the role of vascular risk factors on white matter integrity and temporally coherent networks. The research group is also assessing changes in temporally coherent networks secondary to electroconvulsive therapy.

This required rotation (minimum of ½ day per week for three months) is designed to expose geriatric psychiatry fellows to neuroimaging research. The fellow will learn inclusion and exclusion criteria for various studies and assist with subject recruitment. The fellow will learn to assess patients with standardized scales as well as neuropsychological assessments. The fellow will accompany the patient to imaging sessions. The fellow will become familiar with basic imaging pre-processing steps and data analysis methods. Attending physicians include the following: Chris Abbott, MD; Aaron Brodsky, MD; William Apfeldorf, MD, PhD.

Abbreviations:

PC – Patient Care

CC – Case Conference

MK – Medical Knowledge  
PBL – Practice Based Learning and Improvement  
ICS– Interpersonal and Communication Skills  
PROF – Professionalism  
SBP – Systems-Based Practice

QZ – Quiz  
TR – Teaching Rounds  
FB – Feedback  
DM – Demonstration  
DS– Didactic Seminar  
AR – Assigned Reading  
DO – Direct Observation

**EDUCATIONAL GOALS:**

<b>Fellows will :</b>	<b>Competencies Addressed</b>
Become proficient at administering and scoring standardized psychometric scales and neuropsychological tests.	MK, PC, PBLI, PROF
Assist with subject recruitment and appropriately consent subjects for research.	MK, PROF, ICS
Become knowledgeable with functional magnetic resonance imaging pre-processing steps	MK, SBP
Become familiar with different functional magnetic resonance imaging data analysis methods	MK

**EDUCATIONAL OBJECTIVES:**

<b>By the completion of the rotation, each fellow will have:</b>	<b>Competencies Addressed</b>
Identified and consented for subjects psychiatric research	MK, PROF, ICS
Independently administered and scored psychometric scales and neuropsychological tests	MK, PC
Perform a literature review of a topic within geriatric psychiatric research and participate in geriatric psychiatry journal club	ICS, PBLI, PROF
Present a brief power point research proposal (10 slides) on a topic of interest at the conclusion of the rotation	ICS, PROF, MK

**CORE TRAINING EXPERIENCES:**  
**VETERAN’S ADMINISTRATION (VA) NEUROPSYCHOLOGY**

The VA Neuropsychology Clinic provides outpatient and inpatient neuropsychological and psychological evaluations for veterans with medical, neurological and psychiatric disorders. The core training experiences include individual neuropsychological assessments and weekly

seminar. Individual assessments involve gathering a detailed history, testing, interpretation, diagnosis, treatment recommendations, and communication of results to referents or interdisciplinary treatment teams. The clinic team includes psychology predoctoral interns, practicum students, and neuropsychology postdoctoral fellows. Common referral issues include traumatic brain injury, dementia, decisional capacity, and differential diagnosis of psychiatric and neurological contributions. The Neuropsychology Seminar occurs Wednesday mornings from 10:00 a.m. until noon. The first hour is devoted to review of cases from the clinic week. The second hour includes a range of didactic topics, journal club, test reviews, and mock oral examinations for board certification in clinical neuropsychology.

Fellows will experience the detailed cognitive testing, will participate in clinical interviews, and if desired, will be trained on administration of brief mental status exams. Fellows will develop an appreciation for the strengths and limitations of neuropsychological and psychological testing, and will leave the rotation with a clear understanding of when to refer a patient for neuropsychological testing.

Training Staff: Three full-time clinical neuropsychologists, two of whom are board certified by the American Board of Professional Psychology, Clinical Neuropsychology: Rex M. Swanda, Ph.D., ABPP-CN; Joseph Sadek, Ph.D.; and Kathleen Y. Haaland, Ph.D., ABPP-CN.

PC – Patient Care

PBL – Practice Based Learning & Improvement

ICS – Interpersonal & Communication Skills

MK – Medical Knowledge

PROF – Professionalism

SBP – Systems-Based Practice

AR – Assigned Reading

Staffing

CC – Case Conference

CS – Clinical Supervision

FB – Feedback

DM – Demonstration

DO – Direct Observation

LC – Lecture

MT – Multidisciplinary Team Case

**EDUCATIONAL GOALS:**

<b>Fellows Will:</b>	<b>Competencies Addressed</b>	<b>Clinical Teaching Methods</b>	<b>Didactic Experience</b>	<b>How Assessed</b>
Understand the strengths and limitations of neuropsychological assessment	PC,MK,SBP	CC,CL,AR	CC,CS,LC	DO,CS,MT
Learn criteria for when to refer for neuropsychological testing	SBP,PC,PROF	CC,CS,AR	CC,CS,LC	DO,CS,MT
Enhance bedside cognitive screening skills	PC,MK,	CC,CS,AR,DM	CC,CS,LC, PBL	DO,CS

**EDUCATIONAL OBJECTIVES:**

<b>By the completion of the rotation, each fellow will have:</b>	<b>Competencies Addressed</b>	<b>Clinical Teaching Methods</b>	<b>Didactic Experience</b>	<b>How Assessed</b>
Administer brief cognitive screening	PC,ICS,	PBL,DM,CS	AR,CC	CS,DO
Attend weekly neuropsychology seminar, contribute to case discussion	MT,SBP,MK,PC	CC,CS	CC,LC,FB	CC,DO
At the end of the rotation, present one case to the group	PC,MK,SBP,MT	CC,CS,DM	DM,FB,CL	CC,DO
Review referral questions, critique for relevance	SBP,PC	CS,CC	AR,CL	DO

**ADDITIONAL TRAINING EXPERIENCES**

Additional training experiences are open to fellows to focus on areas of geriatric psychiatry in which they are particularly interested. These experiences are available at the University School of Medicine and the Veteran’s Administration sites. These experiences include: Memory Disorders Clinic, Palliative Care Clinic, Home-Based Primary Care Team, and Electroconvulsive Therapy electives.

**ADDITIONAL TRAINING EXPERIENCES:  
VETERAN’S ADMINISTRATION (VA) PALLIATIVE CARE ROTATION**

Palliative medicine relieves the pain and other symptoms patients suffer due to serious illness, including cancer, cardiac disease, respiratory disease, kidney failure, Alzheimer’s Dementia, AIDS, Amyotrophic Lateral Sclerosis (ALS) and Multiple Sclerosis. The goals of palliative care are to reduce suffering, improve the quality of a seriously ill person’s life, and support that person and their family during and after treatment.

During this elective rotation, the fellow will work among a multidisciplinary team of experts, including palliative care doctors, nurses and social workers. The fellow will have the opportunity to learn about the spiritual, ethical, and clinical issues which arise when treating patients in this context. Attending physicians include: April Volk, MD, Cynthia Geppert, MD

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|---|---|
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| MK – Medical Knowledge                      | DM – Demonstration                        |
| PROF – Professionalism                      | DO – Direct Observation                   |
| SBP – Systems-Based Practice                | LC – Lecture                              |
| AR – Assigned Reading                       | MT – Multidisciplinary Team Case Staffing |

**EDUCATIONAL GOALS:**

<b>Fellows Will:</b>	<b>Competencies Addressed</b>	<b>Clinical Teaching Methods</b>	<b>Didactic Experience</b>	<b>How Assessed</b>
1. Participate in team meetings, inpatient and outpatient palliative care consultations and daily patient care on the inpatient palliative care unit.	MK, PC, ICS, PBL, PROF	CS, DM	MT	DO, FB
2. Identify the criteria for admission to hospice	MK, PC, PBL	CS, DM	AR	DO, FB
3. Function as part of a multidisciplinary team.	MK, PC, ICS, PROF	CS, DM	MT	DO, FB
4. Have a working understanding of commonly used drugs for pain and symptom management	PC, MK,PBL	CS, DM	MT, AR	DO, FB
5. Identify psychological and spiritual issues that impact patients care.	PC, MK,ICS	CS, DM	AR, MT	DO, FB

**EDUCATIONAL OBJECTIVES:**

<b>By the completion of the rotation, each fellow will have:</b>	<b>Competencies Addressed</b>	<b>Clinical Teaching Methods</b>	<b>Didactic Experience</b>	<b>How Assessed</b>
1. Performed consultations, including taking a spiritual history	PC, MK, PBL, ICS, PROF	CS, DM, MT	AR,MT	FB, DO
2. Attended and participated in weekly multidisciplinary team meetings, and daily patient care	PC, MK, PBL, ICS, PROF	CS, DM, MT	AR	FB, DO
3. Learned clinical approach to pain and symptom management in palliative care patients.	PC, MK, PBL	CS, DM, MT	AR	FB, DO
4. Completed assigned readings, and discussed content with supervisor	MK, PBL	MT	AR	FB, DO

5. Given an oral presentation on a palliative care topic of choice	SBP,ICS,PROF	CS,DM	AR	FB,DO
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**ADDITIONAL TRAINING EXPERIENCES:**  
**VETERAN’S ADMINISTRATION (VA) MEMORY DISORDERS CLINIC**

The Memory Disorders Clinic is part of the Neurology service at the Albuquerque VA Medical Service. The mission of the clinic is to assess veterans referred with memory or cognitive concerns, and to manage veterans with cognitive disorders longitudinally. Fellows rotating on this service will participate in the weekly half-day clinic, and learn to perform comprehensive evaluations. This includes a thorough medical and neurological evaluation, a battery of neuropsychological tests, and evaluation of imaging studies. The fellow will learn to interpret the cognitive testing and incorporate these findings into the larger clinical context. The fellow will also learn how to discuss results and prognosis with veteran and the family and to manage presenting symptoms with available treatments. Finally the fellow will be able to participate in the weekly multidisciplinary case conference, in which all new patients are presented, results and imaging reviewed, and treatment plan discussed with neuropsychologist input. The geriatric psychiatrist is often very helpful in this conference, as psychiatric symptoms are frequently part of the clinical presentation. The goal of this rotation in terms of the fellow’s education is to gain more expertise in differentiating between different cognitive disorders, as well as becoming familiar with cognitive instruments that can be applied to future practice. Attending physician: John Adair MD

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PBL – Practice Based Learning & Improvement

ICS – Interpersonal & Communication Skills

MK – Medical Knowledge

PROF – Professionalism

SBP – Systems-Based Practice

AR – Assigned Reading

Staffing

CC – Case Conference

CS – Clinical Supervision

FB – Feedback

DM – Demonstration

DO – Direct Observation

LC – Lecture

MT – Multidisciplinary Team Case

**EDUCATIONAL GOALS:**

<b>Fellows Will:</b>	<b>Competencies Addressed</b>	<b>Clinical Teaching Methods</b>	<b>Didactic Experience</b>	<b>How Assessed</b>
1. Become proficient in comprehensive assessment of veterans presenting with cognitive concerns	MK, PC, ICS, PBL, PROF	CS, DM	AR	DO, FB

2. Learn to perform battery of cognitive tests and interpret results. Determine when it is appropriate to refer for formal Neuropsychological testing	MK, PC, PBL	CS, DM	AR	DO, FB
3. Differentiate between different types of dementia based on clinical presentation, cognitive testing, and imaging studies	MK, PC, PBL, ICS, PROF	CS, DM	AR	DO, FB
4. Become expert in initiating, adjusting and monitoring medications started for dementia	PC, MK	CS, DM	MT, AR	DO, FB
5. Participate in multidisciplinary team meeting to review new patients, and discuss treatment planning	PC, MK, SBP	CS, DM	AR, MT	DO, FB

**EDUCATIONAL OBJECTIVES:**

<b>By the completion of the rotation, each fellow will have:</b>	<b>Competencies Addressed</b>	<b>Clinical Teaching Methods</b>	<b>Didactic Experience</b>	<b>How Assessed</b>
1. Performed multiple initial assessments on veterans	PC, MK, PBL, ICS, PROF	CS, DM, MT	AR	FB, DO
2. Completed cognitive assessments, interpreted results within larger clinical context to clarify diagnosis	PC, MK, PBL, ICS, PROF	CS, DM, MT	AR	FB, DO
3. Initiated medication treatment for dementia and monitored for side effects	PC, MK, PBL, ICS, PROF	CS, DM, MT	AR	FB, DO
4. Served as a psychiatric consultant to the multidisciplinary treatment team regarding presenting psychiatric symptoms	PBL, MK	DM, LC	AR	FB
5. Performed a literature review on relevant clinical topic	MK, SBP	MT	AR	FB, DO

**ADDITIONAL TRAINING EXPERIENCES:**  
**VA MEDICAL CENTER HOME-BASED PRIMARY CARE TEAM**

Home-Based Primary Care (HBPC) is a home care program that provides comprehensive, interdisciplinary, primary care in the homes of veterans with complex medical, social, and behavioral conditions for whom routine clinic-based care is not effective. In contrast to other systems such

as Medicare home care that target patients with short-term remediable needs and provide episodic, time-limited and focused skilled services, HBPC targets patients with complex, chronic, progressive disabling disease and provides comprehensive longitudinal home care. HBPC is designed to serve the chronically ill through the months and years before death, providing primary care, palliative care, rehabilitation, disease management and coordination of care services. The multidisciplinary team includes physicians, nurses, social workers, registered nurse, rehabilitation specialist, and a psychologist.

This elective outpatient rotation (minimum 1 day per week for three months) is designed to train fellows in the comprehensive evaluation and management of geriatric patients in the home care setting. The fellow will serve as a psychiatric consultant to the HBPC, and perform psychiatric evaluations on veterans in need. Common requests for evaluations include behavioral disturbance in the context of dementia, psychotic symptoms, or affective symptoms (depression, anxiety, sleep disturbance). In addition to performing consultation in this team model, the fellow will become acquainted with comprehensive evaluations including functional assessment, PT/OT, and medical evaluation in this population. Fellows will function as part of a multidisciplinary treatment team. Attending physicians include: Donna Parker, MD (Program Director, HBPC), Christina Trevino, MD (Psychiatry supervisor)

PC – Patient Care

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ICS– Interpersonal and Communication Skills FB – Feedback

MK – Medical Knowledge DM – Demonstration

PROF – Professionalism DO – Direct Observation

SBP – Systems-Based Practice LC – Lecture

AR – Assigned Reading

MT – Multidisciplinary team case staffing

**EDUCATIONAL GOALS:**

<b>Fellows will:</b>	<b>Competencies Addressed</b>	<b>Clinical Teaching Methods</b>	<b>Didactic Experience</b>	<b>How Assessed</b>
Become proficient in performing a thorough psychiatric evaluation in the home care setting	MK, PC, ICS, PBL, PROF	CS, DM	AR	DO, FB
Incorporate relevant medical, psychological, nursing and rehabilitation factors in comprehensive psychiatric evaluations.	MK, PC, PBL	CS, DM	AR	DO, FB
Function as part of a multidisciplinary team.	MK, PC, PBL, ICS, PROF	CS, DM	MT	DO, FB
Learn to promote the veteran's maximum level of health and independence by maintaining the optimal physical cognitive and psychosocial functioning.	PC, MK	CS, DM	MT, AR	DO, FB
Learn about assisting the veteran and	PC, MK, SBP	CS, DM	AR, MT	DO, FB

caregiver in adapting the home as needed for a safe and therapeutic environment, and arranging and coordinating support services.				
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**EDUCATIONAL OBJECTIVES:**

<b>By the end of training, Fellows will have:</b>	<b>Competencies Addressed</b>	<b>Clinical Teaching Methods</b>	<b>Didactic Experience</b>	<b>How Assessed</b>
Performed psychiatric consultations on veterans referred by HBPC	PC, MK, PBL, ICS, PROF	CS, DM, MT	AR	FB, DO
Attended and participated in weekly multidisciplinary team meetings	PC, MK, PBL, ICS, PROF	CS, DM, MT	AR	FB, DO
Accompanied home care team on home visits and observed medical, nursing, rehabilitation, and psychological interventions	PBL, SBP, ICS, PROF	n/a	AR	FB
Optimized veteran’s autonomy and health, within treatment planning.	MK, SBP	MT	AR	FB, DO
Performed a presentation to the HBPC on a psychiatric topic relevant to the population.	SBP, ICS, PROF	CS, DM	AR	FB, DO

**ADDITIONAL TRAINING EXPERIENCES:  
ELECTROCONVULSIVE THERAPY (ECT) ROTATION**

The University of New Mexico Electroconvulsive Therapy (ECT) Service maintains patients in an active series (two to three times per week) and a maintenance series (weekly to monthly). The indications for treatment include treatment-resistant depression, bipolar disorder and schizophrenia, and other disorders. The ECT service treats approximately 30 treatment-resistant patients per year and treats another 30 patients on the maintenance schedule. The majority of these patients are inpatient at the UNM Mental Health Center.

This elective rotation (1/2 day per week for three months) is designed to train the geriatric psychiatry fellow in the management of patients during the series and maintenance of patients completing ECT. The geriatric psychiatry fellow will assess the indications for patients referred from the inpatient units. The fellow will also coordinate referrals with pre-anesthesia and appropriate consultations (cardiology, etc). Fellows will learn different methods of stimulus delivery including right unilateral and bitemporal lead placement. The fellow will use the initial ECT session to determine the seizure threshold and adjust subsequent treatments to maximize efficacy. The fellow will learn different mechanisms to lower seizure threshold including hyperventilation, caffeine, increased energy, and different induction agents. The fellow will also learn appropriate indications to discontinue treatment. Attending physicians include the following: Chris Abbott, MD; Aaron Brodsky, MD; Swala Abrams, MD, John Carty, MD (VA).

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|   | AR – Assigned Reading      |
|   | DO – Direct Observation    |
|   | CS -- Clinical Supervision |

**EDUCATIONAL OBJECTIVES:**

<b>Fellows will:</b>	<b>Competencies Addressed</b>
Become an expert in assessing patients for ECT including learning the indications for ECT and working with the primary team and appropriate consultants to minimize risks and side effects of ECT.	MK, PC, ICS, PROF, SBP
Become knowledgeable and skilled at consenting patients for ECT. Fellows will know the risks and benefits of ECT and will be able to effectively provide education to patients and families.	MK, PC, ICS
Become knowledgeable with different anesthetic induction agents and how these agents may affect seizure threshold.	MK, PC, PBLI
Knowledge at reducing cognitive impairment in ECT.	MK, PC

**EDUCATIONAL GOALS:**

<b>By the completion of the rotation, each fellow will have:</b>	<b>Competencies Addressed</b>	<b>Clinical Teaching Methods</b>	<b>Didactic Experience</b>	<b>How Assessed</b>
Complete ECT assessments as requested by the inpatient providers.	MK, PC, PBLI, PROF	DM, CS	AR, TR	FB, DO
Appropriately determine the seizure threshold during the initial treatments	MK, PBLI, PC	DM, CS,	AR, TR	FB, DO
Discussed mechanisms of reducing seizure threshold with anesthesiology attending	MK, ICS, PBLI	DM, CS	AR, TR	FB, DO
Recognized cognitive impairment in individuals receiving ECT and provided appropriate indications	MK, PC, PBLI	DM, CS	AR, TR	FB, DO

## **RESEARCH OPPORTUNITIES**

The Faculty of the Department carries on a variety of research activities, particularly in the areas of clinical psychopharmacology and therapeutics, schizophrenia, affective disorders, substance abuse, post-traumatic stress disorder, neuropsychology, neuroimaging, methodology of clinical research, and behavior disorders in children. The faculty is eager to have fellows participate in their research and help fellows develop their own investigations.

Major resources include outstanding General Clinical Research and Clinical Trials Centers which are available to our faculty. Wet lab space is available for externally funded research.

The MIND Imaging Center is located on the UNM campus. It is operated in partnership with Harvard University, the University of Minnesota, New Mexico Veterans Affairs Health Care System and the National Institutes of Health. The Center's mission is to improve the quality of life for those suffering with mental illness or brain injury. The MIND Imaging Center focuses on the diagnosis and treatment of Alzheimer's disease, schizophrenia and brain injuries such as stroke, trauma and epilepsy. The Center will enable neuroscientists and researchers to work with some of the most advanced neuroimaging equipment available in the United States such as positron emission tomography (PET), functional MRI and magnetoencephalography (MEG). While fellows are not currently rotating at the MIND Imaging Center, fellows oriented to research have opportunities to develop mentorship and research electives. Fellows are encouraged to perform research on an elective basis.

In order to meet the needs of fellows with different levels of interest in, commitment to, and sophistication about investigation, the faculty offers two broad categories of research experience: 1) fellows may participate in ongoing studies by faculty members, or 2) fellows may develop and carry out their own original research with a faculty member as a mentor. All research must be approved by the appropriate departmental and Health Sciences Center Committees.

## **DIDACTIC EDUCATIONAL PROGRAM**

The didactic program provides fellows with opportunities to develop competencies in medical knowledge, patient care, practice-based learning, professionalism, systems based learning and improvement, interpersonal and communication skills. The seminar format also provides opportunities to improve interpersonal and communication skills and professionalism.

The didactic educational program is scheduled every Friday morning; no clinical activities are scheduled or expected during this time.

Finally, the Department sponsors a weekly series of Grand Rounds which runs Labor Day through Memorial Day, fellows are encouraged to attend. This series offers an unusually rich diversity of clinical and research presentations, mostly by outstanding academic psychiatrists from other institutions. Fellows also are encouraged to take part in approved educational experiences, usually CME sessions, at other institutions at least once each year. Fellows may take up to 5 days of educational leave yearly for this purpose.

**Geriatric Psychiatry (Geropsychiatry) Seminar**  
**Friday Mornings, University Psychiatric Center offices**

Seminar Description: This year-long seminar for all geriatric psychiatry fellows provides a review of topics in Geriatric Psychiatry, including normal aging; psychiatric diagnoses with special emphasis on their geriatric presentation; evaluation and differential diagnosis; comorbidities and associations; psychotherapy; continuum of care; legal and ethics issues; and treatment.

Seminar Leaders: Aaron Brodsky, MD

Goals: To understand the psychopathology and treatment of the major DSM-IV-TR disorders that affect the elderly, and the evaluation and management of these disorders. (Competencies addressed; Medical Knowledge, Patient Care, Interpersonal & communication Skills, Professionalism, System-Based Practice)

Medical Knowledge Objectives:

- 1) Develop a sense for normal aging as a backdrop against which fellows can begin to accurately discern psychopathology
- 2) Demonstrate knowledge of universality of normal aging and how cultural context may influence normal aging
- 3) Demonstrate knowledge of different theories of normal aging
- 4) Demonstrate knowledge of the categories of geriatric psychiatric disorders
- 5) Demonstrate knowledge of the DSM-IV diagnoses relevant to geriatric psychiatry
- 6) Demonstrate knowledge of the geriatric phenomenology and presentation of the major diagnoses
- 7) Demonstrate knowledge of Neuropathology associated with geriatric psychopathology
- 8) Demonstrate knowledge of how geriatric psychopathology is influenced by development and differs from adult psychopathology.

Patient Care Objectives:

- 1) Recognize key features of psychiatric diagnoses in the senior years;
- 2) Accurately categorize psychopathology in geriatric patients;
- 3) Formulate and consider key differential diagnoses and comorbidities when considering a specific diagnosis;
- 4) Apply the existing empirical knowledge base to the diagnosis and treatment of geriatric psychiatric disorders.

Interpersonal & Communication Skills Objectives:

- 1) Demonstrate the knowledge of working with families of geriatric patients
- 2) Participate in and guide discussion during seminar

Professionalism Objectives:

- 1) Demonstrate knowledge of how the nature of aging and medical illness affects the responsibilities of physicians in care of the geriatric patient

Systems-Based Practice Objectives:

- 1) Integrate and Apply knowledge of social & economic factors to the treatment of older adults
- 2) Demonstrate knowledge of legal and ethical systems of care of older adults
- 3) Demonstrate knowledge of clinical psychiatry in the Nursing Home environment
- 4) Demonstrate knowledge of and apply the multidisciplinary nature of psychiatric care for the aged.

**Geropsychiatry Journal Club and Evidence Based Medicine Seminar  
Mondays 4:15-5:15 PM, Roadrunner Conference Room**

**Seminar Description:** This is a dual purpose seminar, combining:

- (1) Geropsychiatry journal club where participants read key articles in Geriatric psychiatry, chosen by faculty.
- (2) seminar on evidence based medicine (EBM) with participants conducting literature searches to answer clinical questions

**Goals:** To increase faculty and residents' ability to apply the principles of EBM to critically appraise the geriatric psychiatry literature and to use the literature to answer questions of relevance to their clinical practice and research interests, and to critically review key articles in Geriatric psychiatry.

**Objectives:** By the end of the year, residents will:

- (1) Have critically appraised and discussed (with other residents and faculty) 7-8 key articles in Geriatric psychiatry (Competencies Addressed: Medical Knowledge, Patient Care, Practice-Based Learning and Improvement, Interpersonal and Communication Skills)
- (2) Have written two case-based clinical questions, searched the literature, and critically reviewed applicable articles. (Competencies Addressed: Medical Knowledge, Patient Care, Practice-Based Learning and Improvement)
- (3) Have searched the literature and critically reviewed applicable articles based upon other participants' questions. (Competencies Addressed: Medical Knowledge, Patient Care, Practice-Based Learning and Improvement, Professionalism)

**Key Article Procedure:**

- Faculty member chooses article for participants to read, and sends an electronic copy of it to Division Office (Debra Kincaid and Angela Larkin) at least one week prior to journal club. It will be place on New Innovations, and e-mailed to participants who are to read it before the Journal club in which it will be discussed.
- Article may be on any topic of relevance to Geriatric psychiatry, and may be clinical trial, commentary, review article, etc. but should be of significant importance to the field.
- Faculty member leads discussion of the article, including critical appraisal of the article's strengths and weaknesses.
- Faculty may do Journal Club in a Team Based Learning format, in which case they submit questions with the Journal Article. Fellows answer the questions individually prior to Journal Club, then work on the questions in small group then large group during Journal Club.

### **EBM Journal Club Procedure:**

- Fellows work alone or paired with faculty. They develop a clinical vignette with a clinical question at the end and distribute it to participants at the Journal club preceding the Journal club in which they will be presenting.
- Clinical question should be in PICO format (Patient or Problem, Intervention, Comparison, Outcome)
- Participants search the literature for articles relevant to the clinical question, and e-mail them to the fellows.
- Fellows choose the 1-2 articles most relevant to the clinical question, and send an electronic copy of article(s) to Division Office (Debra Kincaid/ Angela Larkin) at least one week prior to journal club. Article(s) will be place on New Innovations, and e-mailed to participants who are to read article(s) before the Journal club in which article(s) will be discussed.

<p><b>Departmental Conference Series “Grand Rounds” 2010-2011</b>  <b>Fridays September-May, 11:00 AM, Domenici Auditorium</b></p>
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Seminar Description: This weekly conference series, held every Friday from September through May, is required for geriatric psychiatry fellows. Grand Rounds are organized in 4 week blocks, covering neuroscience, child/adolescent psychiatry, addictions/dual diagnosis, geriatric psychiatry, research, and general psychiatry. Speakers include experts from across the country.

Seminar Leaders: Senior faculty in the Department of Psychiatry and Guest Speakers

Goal: To learn new and key topics in psychiatry from local and national experts. (Competencies addressed: Medical Knowledge, Patient Care)

Patient Care Objectives:

Apply new knowledge in psychiatry in the care of patients

Medical Knowledge Objectives:

Demonstrate knowledge of topics in neuroscience, child/adolescent psychiatry, addictions/dual diagnosis, research, and general psychiatry

Practice-Based Learning & Improvement Objectives:

Use new, evidence based information to change clinical practice as indicated

**Geriatric Medicine Interest Rounds Conference Series “Grand Rounds” 2010-2011  
Wednesdays July- June 8:30-10:30 AM, 1009 Bradbury SE, Room 031**

Seminar Description: This recommended weekly conference series, held every Wednesday from July through June from 8:30-10:30 AM at 1009 Bradbury SE, Room 031, is recommended for geriatric psychiatry fellows. Geriatric Medicine Interest Rounds are organized in monthly blocks, covering geriatrics and aging, palliative care, community care/resources, Mobility/musculoskeletal issues in the elderly, dementia and delirium, geriatric psychiatry, endocrine disorders, uro-genital disorders, GI problems/common geriatric syndromes, and neurological diseases and disorders. Speakers include experts from across the country.

Seminar Leaders: Senior faculty in the Department of Medicine and Guest Speakers

Goal: To learn new and key topics in geriatric medicine from local and national experts.  
(Competencies addressed: Medical Knowledge, Patient Care)

Patient Care Objectives:

- Apply new knowledge in geriatric medicine in the care of patients

Medical Knowledge Objectives:

- Demonstrate knowledge of topics in neuroscience, geriatric psychiatry, addictions/dual diagnosis, research, and general geriatric medicine

Practice-Based Learning & Improvement Objectives:

- Use new, evidence based information to change clinical practice as indicated

## **EXAMINATIONS**

### **I. Geriatric Psychiatry Self Assessment Program**

All fellows are required to engage in the Geriatric Psychiatry Self Assessment Program (GPSAP.) This is a self-examination which the fellows use throughout their training year in preparation for future Board Geriatric examinations. The Department pays the fee for the examination. This examination is a means of evaluating competency in medical knowledge and patient care, however the examinations will not be the only method used to evaluate fellows, but will be one of many factors used to assure that fellows are acquiring adequate knowledge. It is hoped that these examinations can further be used as a study guide for each fellow and also as an indication for faculty as to how our fellows are progressing in knowledge and in which areas our training needs to be strengthened.

### **II. USMLE**

Fellows are required to have passed Steps I, II and III (Clinical Skills and Clinical Knowledge) of the USMLE (or COMLEX) prior to admission to the program.

#### **PART II**

### **POLICY STATEMENTS OF THE DEPARTMENT OF PSYCHIATRY FELLOWSHIP EDUCATION**

#### **FELLOW SELECTION**

**PURPOSE:** To insure a fair and adequate process for evaluating and selecting applicants for training in psychiatry as interns.

**PROCEDURES:**

The training director and the assistant training director screen all applications to the fellowship. The training director, along with core training faculty, then reviews all completed applications and invites qualified applicants for interview. Decisions are based on information from the medical school, fellowship, and letters of reference, personal statement, C.V., and test scores such as the USMLE. This information is kept in the fellowship training office.

Interviews are arranged for applicants with core faculty of the fellowship and attending faculty from the clinical teaching sites. Applicants meet with fellows over lunch.

Each department member who meets with an applicant completes an assessment of the applicant and returns it to the training director's office.

Interviews generally occur between August 1 and January 25.

The Fellowship Director, core faculty and the Residency Training Committee individually review applications of all those interviewed individually. Decisions are based on the academic record, letters of reference, personal statement, C.V., test scores and interview ratings of the faculty who met with the applicant.

The Geriatric Fellowship does not participate in the Match.

All candidates must have a sufficient command of English to communicate accurately and without impediment with patients, teachers, staff and colleagues.

All candidates must have graduated from an Accreditation council for Graduate Medical Education (ACGME) accredited general psychiatry residency program.

All candidates must have passed USMLE I, II, and III, or COMLEX equivalent.

### **CONTINUITY OF CARE OF PATIENTS FOLLOWING FELLOWS' GRADUATION**

**PURPOSE:** To insure that patients receive appropriate and necessary follow up care when fellows graduate from or otherwise leave the program.

**POLICY:**

1. Patients who are receiving care within an established clinic or program may be transferred to a clinician within that program through the same procedures that are used when fellows transfer to other services. Fellows will take the responsibility of arranging this transfer and identifying the receiving clinician.
2. Continuity patients who have been followed by fellows for medication management and supportive therapy may need ongoing care. When not seen through an established clinic or program, these patients may be transferred to a clinic for their ongoing care. Fellows are responsible for establishing this ongoing treatment.
3. Long term psychotherapy patients may wish or need to have ongoing treatment. These patients should be discussed with the supervisor of the case. If ongoing psychotherapy is recommended, the psychotherapy supervisor and fellow will work together to find appropriate follow-up.
4. In the event that the graduating fellow plans to enter private practice in this area, they may wish to consider providing ongoing care for their patients. This should be discussed with supervisor(s), the clinic directors and the training director. Clinical and ethical issues must be

thoroughly discussed. The patient's welfare is the primary consideration in making the decisions among transfer options.

### **PAGERS (From the GME Houseofficer's Handbook)**

**PURPOSE:** To insure that attending physicians and co-workers can contact fellows when needed for patient care and other related responsibilities.

**POLICY:**

1. Fellows must have their pagers turned on at all times during regular work hours (8am-5pm).
2. Unless actively involved in patient care, fellows should attempt to respond to pages within fifteen minutes of receiving the page.
3. Fellows must provide the fellowship training office with up-to-date contact information in case of an emergency.

### **GERIATRIC PSYCHIATRY FELLOWS' GRADUATION REQUIREMENTS**

**PURPOSE:** To clarify the specific requirements that must be fulfilled for graduation from the UNM Department of Psychiatry geriatric fellowship program.

**POLICY:**

1. 12 months continuous outpatient psychotherapy
2. 6 to 12 months of inpatient psychiatry.
3. 12 months nursing home experience
4. 3 months neurology/neuropsychology.
  - a. Approved electives as individually planned with the Program Director to fill remaining clinical time during the fellowship.
5. 12 months consultation/liaison psychiatry.
6. Demonstration of competency in supportive, psychodynamic, and cognitive-behavioral psychotherapies, as determined by evaluations of the fellow by their case supervisors.
7. Through various evaluation processes, all residents will have demonstrated competency in medical knowledge, patient care, systems-based practice, professionalism, interpersonal communication, and practice-based learning.

8. Seminars: must attend at least 70% of all required seminars.
9. At least one oral presentation to a consumer, general public, multidisciplinary group (e.g. DMDA, NAMI, and Grand Rounds formats are appropriate such groups), or to students in a medical field. Routine clinical presentations are not acceptable. Routine teaching in clinical settings, to families, students, or staff are not acceptable. A clinical presentation with psychiatric literature review or a research project is acceptable. The fellow may submit a written paper instead if approved by the training director.
10. Record of cases seen by resident. A variety of patients, diagnoses, and treatment modalities must be a part of this record.

**UNM PSYCHIATRY GERIATRIC FELLOWSHIP TRAINING PROGRAM**  
**POLICY ON GRADUATED LEVELS OF SUPERVISION**

The University of New Mexico School of Medicine is committed to safe and high quality psychiatric care and training in a supportive educational environment.

Geriatric Psychiatry fellows in training are at all times supervised by an assigned attending physician in all settings, e.g. clinical attending, hospital attending, nursing home attending, etc. All such assignments are arranged, scheduled, and overseen by the Program Director.

Depending on the site and the rotation, supervision may be direct or indirect. Direct supervision need not be continuous/on site and may occur at specified times such as teaching rounds, but with immediate availability at all other times. In all settings, supervision will be continuously available. An attending physician will be present in the same ward or clinic when the fellow is seeing outpatients; the fellow must present the case to the physician faculty prior to the patient leaving the clinic. In long-term care settings, supervision can occur at the end of the session but faculty will always be present on-site for assistance and reporting as required. Fellows may participate in some rotations (nursing home experience) without on-site supervision, but at all times and in all sites a designated supervising attending physician must be immediately available by telephone/pager for assistance if needed and must review all patient visits, documentation, and bills (if applicable) with the fellow in a suitable time frame to meet the requirements of patient care as well as billing

Fellows will be given progressively increasing responsibility and autonomy as appropriate to their experience and performance, but also must at all times be clear on the scope and limits of their authority, responsibility, and capabilities, and should freely ask for assistance when

needed/appropriate. Fellows should always be cognizant of exactly who is their direct supervisor in any activity or setting. It is possible at times for more than one attending physician to be supervising a fellow at the same time, e/g. if multiple geropsychiatrists are present in the same clinic or conference, in which case supervisory responsibility may be shared, with ultimate authority still resting with the Program Director. In some sites (clinics, nursing homes, hospitals,) there may also be a site medical director, or other site official who should also be consulted as appropriate.

## **DUTY HOURS POLICY**

### **Duty Hours**

Duty hours are defined as all clinical and academic activities related to the psychiatry fellowship training program, i.e. patient care, administrative duties related to patient care, and academic activities such as seminars and conferences. Duty hours do not include studying and preparation time spent away from the hospital. Although fellows do not take any type of call, we adhere to the ACGME Duty Hours rules, and the Department policy as listed below.

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

Fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational and administrative activities.

A 10-hour time period for rest and personal activities must be provided between all daily duty periods and after in-house call.

Fellows are not allowed to take new patients after 24 hours of continuous duty. After 24 hours of continuous duty, an additional 6 hours of duty are permissible to assure continuity of care to patients, to permit safe hand off of patients, and for educational activities. There must be no on-site clinical or required educational activity in any form after 30 hours of continuous duty.

### **Moonlighting**

Moonlighting is permitted in the Geriatric Psychiatry Fellowship. The program director will ensure that moonlighting does not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.

The program director will comply with the UNM School of Medicine Graduate Medical Education's written policies and procedures with regard to moonlighting.

Moonlighting that occurs within the UNMHSC (internal moonlighting) and through Locum Tenens (external moonlighting) must be counted toward the 80 hour limit on duty hours. Fellows must have at least three nights between moonlighting and/or call periods. Fellows may work no more than two nights per week.

#### Oversight

This policy must be distributed to fellows and faculty. Monitoring of duty hours will occur on an on-going reporting system. The fellows will enter their hours worked into the duty hours module of New Innovations no less frequently than weekly. This provides the training office an ongoing monitoring system to insure fellows stay within duty hour limits.

Back up support will be provided when patient care responsibilities are unusually difficult or prolonged or if unexpected circumstances create fellow fatigue sufficient to jeopardize patient care.

### **MOONLIGHTING**

**PURPOSE:** To insure that any moonlighting activity undertaken by a fellow while in training does not cause the fellow's work week to exceed 80 hours, does not interfere with the fellow's patient care or learning abilities, is in an area that the fellow has received training prior to undertaking the moonlighting, that the fellow is aware of the need for liability coverage, and that the fellow is in good standing with the program.

#### **POLICY:**

Fellows considering external moonlighting will fill out the Moonlighting Request Form (available in the GME office) and discuss their plans with the training director.

The Residency Training Committee will review all requests for moonlighting approval. If approved, the fellow then coordinates moonlighting through the HSC Locum Tenens Program.

Weekend moonlighting should be no more than one weekend per month. Fellows participating in in-house moonlighting should not schedule themselves more than 4 times per month, with no moonlighting interval of less than 3 days.

All external moonlighting must be re-approved each academic year.

No moonlighting will be allowed during regular work hours.

All moonlighting will be reported to the Graduate Medical Education office and the Locum Tenens office.

Fellows on probation or identified as having academic or other difficulties will not be approved for moonlighting.

Fellows are not to participate in moonlighting activities outside of the institution, unless arranged through the procedures outlined above. If fellows engage in such unapproved moonlighting, they are operating as their own agents. The University of New Mexico and the Department have no responsibility or liability for work done by fellows who are engaged in unapproved moonlighting. Fellows engaging in such activities should expect to provide their own liability insurance, state medical license and any other credentials required by the moonlighting site. To engage in such unapproved moonlighting will be considered a breach of professionalism, and subject to the usual review procedures for violation of professionalism.

### **PREVENTION AND MONITORING FELLOW FATIGUE**

- A. Responsibility - It is the responsibility of the Psychiatry Training Program to prevent fatigue that adversely affects the ability of psychiatry fellows to learn, sustain empathy and compassion for their patients, and to provide appropriate and high quality patient care.
  - a) The Training Program is committed to promoting an optimum environment for training, including the working within ACGME guidelines for duty hours and on-call experiences.
- B. Prevention of fatigue
  - a) The creation of a learning environment that minimizes the need for excessive duty hours or on-call activity is the primary tool the program has to decrease fellow fatigue.
    - i) The training Program and the Department are committed to preventing excessive fatigue is through structure of the training experience. is structured so that duty hours should not routinely approach the limits defined by ACGME policies. Guidelines on duty hours and call activities are delineated in the DUTY HOURS POLICY and ON-CALL POLICY contained in the House-officer Handbook.
- C. Conditions that promote fatigue
  - a) Some conditions may be expected to increase the risk for significant fatigue. In our program, these times include
    - i) When circumstances (e.g., covering fellow fellows' absences due to illness, vacation, or emergency, medical emergencies arising in clinical training sites) result in extended duty hours.
    - ii) Moonlighting. Internal moonlighting allows the department to carefully define the conditions and supervision of the fellows who choose to moonlight. However, hours spent moonlighting are additional duty hours, and the fellow and the program must consider the effects of moonlighting on fatigue. As stated in the policy on Moonlighting in the handbook, moonlighting cannot affect a fellow's ability to learn or provide patient care.
      - (1) The presence of fatigue in a fellow who is engaged in moonlighting will be sufficient grounds for cessation of moonlighting until the fellow can demonstrate sustained periods without fatigue.

- D. In the presence of these potential causes for excessive fatigue, it becomes essential that fellows and faculty recognize signs of fatigue.
  - a) Responsibility to prevent, and to recognize fatigue, falls in part on fellows themselves.
    - i) Attachments to this policy include an outline for the Recognition of Fatigue.
    - ii) This includes becoming aware of the signs of fatigue (attachment: Recognition of Fatigue), acting in a way to maximize rest when away from the program (attachment: Strategies to Decrease and Prevent Fatigue), and a willingness to acknowledge being fatigued when it occurs.
- E. The effects of fatigue can put fellows at risk of motor vehicle injury.
  - a) To help decrease the risks of driving error when fatigued, there is information in the attachment Strategies to Decrease and Prevent Fatigue designed to help fellows recognize and cope with fatigue related driving problems.
    - i) As per the current collective bargaining contract fellows who are fatigued post call may be reimbursed for the cost of cab services, not to exceed \$50 total utilized for transportation home.
- F. Fellows have the opportunity to report excessive fatigue to their attending physicians.
  - a) Fellows have a responsibility to enter accurate duty hours into New Innovations.
  - b) Episodes of significant fatigue should be reported to supervisors. Should a problem arise with unwillingness on the part of the attending or other staff to acknowledge the presence of fatigue, or its short-term remediation, the fellow should notify the Training Director or the Vice-Chair for Education. Such occurrences will be dealt with on a case-by-case basis.
  - c) Evidence supports the use of naps, of at least 30 minutes, to restore useful alertness.
- G. Faculty who observe fatigue that appears to impair performance are obliged to address it directly with the fellow, and may also notify the Training Director. Immediate actions should involve removing the fellow from clinical responsibilities, and/or providing the fellow with the opportunity for a nap as described above.
  - a) If there is a recurrent problem with fatigue in a fellow, the Training Program and the fellow will work on an individual plan to eliminate the causes of fatigue.

### **RISK MANAGEMENT FOR HOUSE STAFF**

**PURPOSE:** To clarify the coverage available for HOUSE STAFF while practicing within the UNM Department of Psychiatry fellowship program.

**POLICY:**

1. The Veterans Administration Medical Center covers work done by HOUSE STAFF at their programs.
2. All work performed at the University Hospital, University Psychiatric Center, and Children's Psychiatric Hospital and Clinics is covered by the University of New Mexico Risk Management department.

3. Rotations at non-university facilities are also covered by the University of New Mexico Risk Management department so far as these rotations are pre-approved by the fellowship director and are a part of the training program for which the fellow is receiving credit toward the ABPN.

4. Moonlighting activities outside of the institution are not covered by the University or the Department of Risk Management, except as per the House-Officers and the University Regulation and Benefit Manual policy on UNM HSC SOM Locum Tenens Policy.

### **EVALUATION OF FELLOW PERFORMANCE**

**PURPOSE:** To insure that fellows and the training director receive frequent, comprehensive and varied evaluations of fellows' performance in all areas of the program. Evaluations are intended to provide feedback for areas of both strengths and weaknesses so that fellows can address areas that need improvement and make sound decisions about their careers. Evaluations will insure that fellows have developed competency in medical knowledge, patient care, professionalism, systems based practice, interpersonal and communications skills, and practice based learning.

#### **POLICY:**

1. Competency based evaluations will be made for each clinical rotation. The attending providing supervision of that rotation will complete the formal evaluation provided in New Innovations web-based Residency Management Suite. In the event that more than one attending provided supervision, each attending may complete an evaluation or the attending may provide a composite evaluation.

2. Psychotherapy supervisors are encouraged to complete a formal competency based evaluation every six months.

3. Each evaluator is asked to discuss his or her evaluation with the fellow and the fellow is asked to sign the evaluation indicating that they have reviewed the evaluation with the evaluator. Should the fellow disagree with the evaluation they may so indicate and may request to meet with the fellowship training director to discuss the disagreement in evaluation.

6. All evaluation materials are collected in the Fellowship Training Office and are available to review in New innovations. Fellows are encouraged to review their evaluations on a regular basis.

7. All fellows meet with the Training Director twice each year to review competency evaluations. Fellows will also provide feedback on their experience of rotations, supervision, didactic courses and any other aspect of the program.

8. Fellows provide written evaluation of each clinical rotation, supervisor, and didactic course. These are gathered by the Training Director. The Residency Training Committee promotion and professionalism reviews the abstracts of these evaluations. The feedback of the fellows is used in planning changes in the program and is given to the attendings, Vice Chair for Education, and the Chairman in abstracted form. The evaluations of faculty performance are collected and provided to the appropriate Vice-Chairs for consideration in annual performance reviews.

## **REGISTERING FELLOW CONCERNS AND COMPLAINTS**

### **PURPOSE:**

The purpose of this policy is to insure that fellows feel safe to express concerns about their clinical experience, their education, and their treatment by staff and faculty. The policy also provides an outline for mechanisms that allow fellows express such concerns.

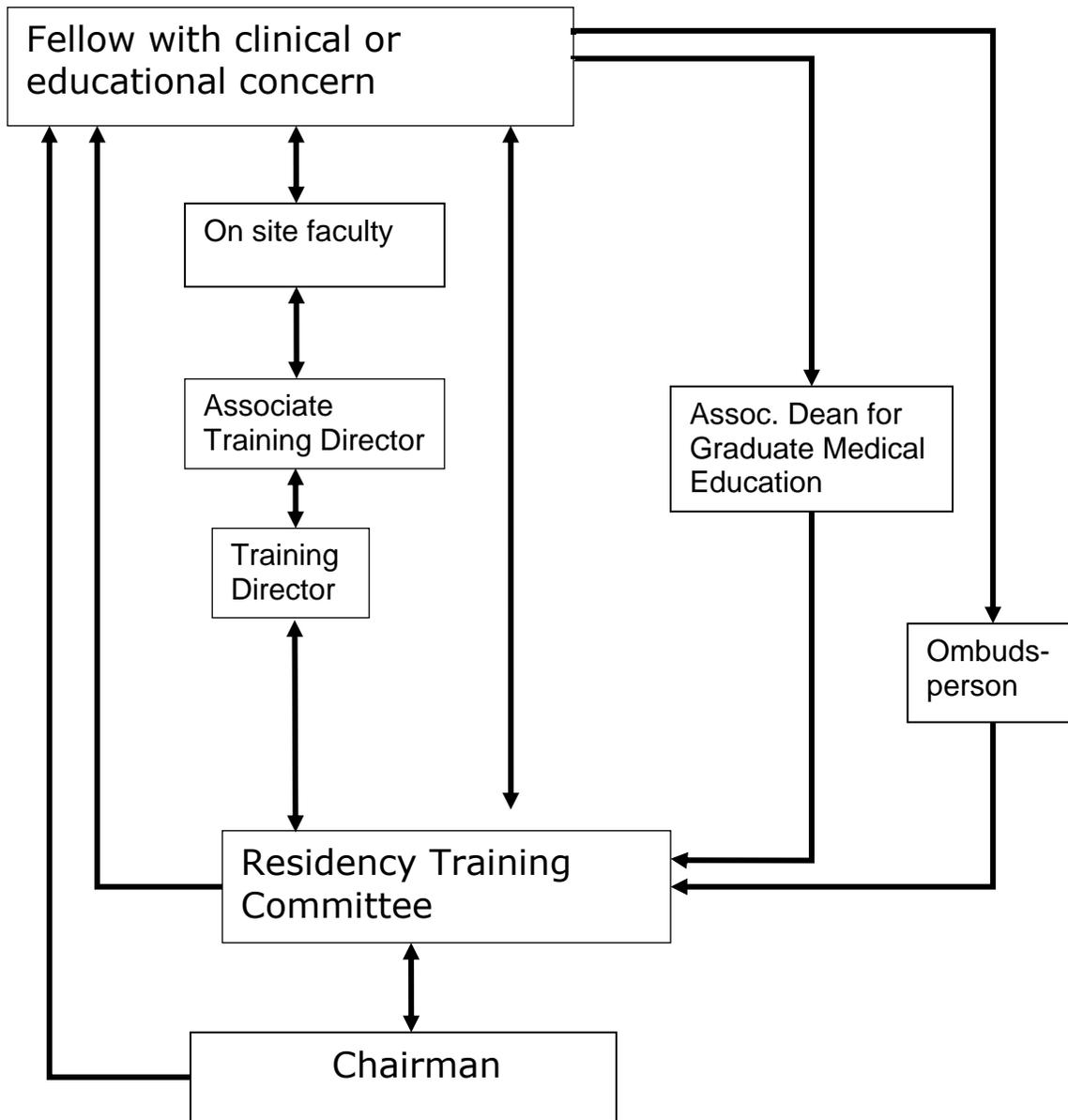
### **POLICY:**

The policy of our department is that fellows should be able to report concerns about problems with their clinical education, formal didactic experiences, treatment by hospital staff and the teaching faculty, and their safety. Reporting concerns about problems in should not put fellows in a position where they might be subject to intimidation or retaliation. To insure that fellows can feel safe to report problems clinical education, formal didactic experiences, treatment by hospital staff and the teaching faculty, and their safety, there are multiple reporting mechanisms available.

#### **A. Plan for reporting**

- a. Most problems are best addressed at the site of the problem, and fellows are encouraged to review their concerns at the level of authority closest to the site.
  - b. Report to faculty at the clinical site, or the Associate Training Director at the site.
  - c. If there are concerns about reporting on site, report to the Fellowship Training Director.
  - d. The person or entity receiving the complaint 3) a. through 3) d. above can then report to the Residency Training Committee (RTC).
  - e. If there are concerns that reporting through the Psychiatry Department hierarchy might lead to retaliation, reports and complaints can go outside the department to the Associate Dean for Graduate Medical Education (GME).
  - f. If there are concerns about reporting to the Associate Dean for Graduate Medical Education, or if preferred by the fellow, the complaints and suggestions can be made to the GME Ombudspersons
- B. The RTC can act directly to respond to most complaints; where they cannot act they can address concerns to the Department Chair. Similarly, GME can act on some complaints directly, and GME and the Ombudsman can report concerns and complaints to the Training Director, the RTC, or the Department Chair.

*A chart diagramming the reporting pathways is included below:*



## **DIDACTIC SEMINARS**

**PURPOSE:** To insure fellows the opportunity to learn in a scholarly fashion the body of knowledge that contemporary geriatric psychiatry comprises. This diverse and complex area of learning demands an opportunity to set aside clinical responsibilities for a period of time to systematically explore the various topics with experts in that field. The didactic courses are developed so that they are appropriate to the fellows' level of training, can be clinically as well as theoretically sound and cover the biological, psychological and sociocultural aspects of our field. Seminars also provide a forum for fellows to develop competency in interpersonal communication skills, professionalism, and practice-based learning.

### **POLICY:**

1. One morning each week is set aside for Geriatric Psychiatry didactic seminars. These include the Geriatric Psychiatry Seminar and the Department Conference Series/Grand Rounds. Fellows are excused from clinical services to attend these seminars. Journal Clubs and Case Conferences will be scheduled within their associated clinics. Recommended, but not required, Geriatric Medicine Interest Rounds require the fellow to arrange to be excused from clinical service to attend.
2. The seminar series will be coordinated by faculty of the Geriatric Fellowship, and associated School of Medicine faculty (depending on the topic), who will work with the Fellowship Office to establish a curriculum appropriate to the level of training.
3. One faculty member will be identified to oversee each seminar. This faculty member will be responsible for articulating the learning objectives and developing the specific curriculum of the course. This will be reviewed by the coordinator and by the training director.
4. Each faculty member supervising a course will have the responsibility to address the course of illness, etiologies, prevalence, diagnosis, treatment and prevention as is pertinent to the subject matter of the course. The format of the Geriatric Psychiatry seminar is a discussion style seminar.
5. Fellows are required to attend the seminars presented. The training director may modify the sequence of courses for fellows to prepare fellows for specific clinical experiences. Fellows are required to be on the appropriate leave status if they do not attend their seminars. As per ACGME requirements, seminars are scheduled so as to insure fellows can attend, and fellows must attend at least 70% of scheduled lectures, the fellowship expectation is 100% attendance when not on leave. Attendance is logged weekly by the fellowship office. Fellows who do not attend 70% of the scheduled didactic activities will be required to provide explanation for not meeting the expectation of attendance.
6. Course presenters and coordinators may evaluate the fellows to ensure that participation is adequate to acquire knowledge, develop interpersonal and communication skills, demonstrate commitment to practice based learning and professionalism. Feedback concerning any problems

in participation is addressed with the fellows by the course presenters, coordinators, or the Training Directors and Associate Training Directors.

7. Schedules for the didactic seminars will be provided to the fellows at the start of the fellowship.

### **PERFORMANCE PROBLEMS AND PROBATION (DUE PROCESS)**

**PURPOSE:** To insure that difficulties in performance undergo due process and are brought to the fellow's attention in a timely and constructive fashion so the fellow can address and remediate these problems. In cases where problems are severe, and performance is not remediated through standard supervisory channels, a fellow may be placed on probation. Probation is an opportunity for the fellow to bring his/her performance to a satisfactory level with the aid of more intensive counseling, teaching and monitoring.

#### **POLICY:**

1. Clinical supervisors have the responsibility to identify and discuss with the fellow problems in competence, responsibility, fulfillment of assignments, acquisition of necessary knowledge and skills, ethical and interpersonal problems, and any other aspect of the professional practice of psychiatry. Supervisors should provide reasonable opportunities and directions to support the fellow in remediation of his/her problems.
2. Clinical supervisors must contact the fellowship training director if they have serious concerns about a fellow's performance, find that remediation is not working satisfactorily, need consultation in working with the fellow or have concerns that the fellow will not satisfactorily complete the rotation. These supervisors will complete a written or on-line evaluation of the fellow's performance.
3. When the fellowship training director has been consulted by a clinical supervisor(s) regarding a fellow's performance, the fellowship training director will usually meet with the fellow. The fellow will have an opportunity to reply to the supervisor's evaluation in writing. In the event that the training director decides that further remediation is needed s/he will notify the fellow in writing, and again meet with the fellow to discuss the specific problem area and to work on goals and objectives for remediation. Remediation may include any or all of the following or other approaches that are appropriate: 1) further discussions with the training director, 2) meeting with supervisors, 3) adding supervision or other remedial work, 4) adjusting the fellow's schedule. Further steps that might be taken, including: 5) adding a clinical rotation to supplement the fellow's skills, 6) voluntary leave of absence, 7) personal psychotherapy or other appropriate treatment, 8) voluntary transfer or termination, would fall into the category of disciplinary action, and the fellow and the CIR/SEIU representative would be notified of the

contemplated action in writing. The fellowship training director will consult with the Residency Training Committee, the Vice Chair for Education, and the Chairman.

4. In the event that adequate remediation is not achieved or if the seriousness of the problem is deemed severe, the fellowship training director may recommend to the faculty of the Residency Training Committee that the fellow be placed on probation. The faculty of the Residency Training Committee will review the evaluations; meet with the supervisor(s) and with the fellow. If the Committee recommends probation, the Chairman of the Department of Psychiatry will be consulted. With the chairman's agreement, the fellow will be placed on probation.

5. Probation may be appealed to the GME office in accordance with the rules in the House-officers and the University Regulation and Benefit Manual, which establishes policies for grievances, impaired physicians, and ethics.

6. A written statement of the problem area(s) and the plan for Remediation will be given to the fellow placed on probation with a copy to the Chairman. This statement will specify the actions or deficiencies that led to the recommendation for probation. The conditions, including the length of the probation (usually 1 to 6 months), will be specified. The specific changes that are expected will be identified along with the specific actions that will be taken to help the fellow make the required changes. These will be defined for all supervisors involved with the fellow's clinical work and remedial activities.

7. The training director or his/her designee will meet with the fellow at least every two months to review the fellow's progress. The fellow may request that the faculty of the Residency Training Committee review the probationary status at any point. Depending upon the circumstances, the Residency Training Committee may require that the fellow not be allowed to take call or perform other clinical duties unsupervised. The fellow may be denied credit for the probationary months if the level of performance for any reason does not meet the standards of the department.

8. At the end of the probation, the following may occur:

A. Termination of Probation. A statement will be placed in the house officer's record that the conditions of probation were satisfactorily resolved and the issues are no longer considered to be a serious problem.

B. Continuation of Probation. An additional specified period of time may be added with a redefining of the problem and remediation plans if the Committee is not satisfied with the progress of the fellow.

C. Premature Dismissal. If the faculty of the Residency Training Committee believes that the fellow has not adequately remediated the problem(s) and/or that retention of the fellow would jeopardize patient care or welfare, the fellow will be placed on temporary suspension. The fellow may appeal this decision to the Chairman of the Department of Psychiatry. If the Chairman supports the suspension, the fellow may appeal to the GME office.

D. Dismissal. If the fellow chooses not to appeal the decision or the decision is upheld through the University process, the fellow will be dismissed.

## **LEAVE POLICY**

### **I. Procedure**

Fellows are encouraged take 1 week of leave every 4 months to ensure against “burnout.”

Fellow should contact the coordinator first when requesting leave to determine amount of available leave and receive a leave request form.

Fellow will need approval of all rotation supervisors and the training director, as well as coverage for all planned leave.

Fellow should turn in the completed leave request form to the coordinator at least 30 days prior to leave.

Maternity, paternity, and planned medical leave (e.g., for scheduled procedures) will be scheduled separately.

UNM GME policy states that no leaves should be scheduled and paid during the week at the beginning of the contract. Fellows must have leave approved prior to making travel arrangements.

### **II. Leave days**

The policies regarding Annual Leave, Bereavement Leave, Catastrophic Leave, Educational Leave, Maternity/Paternity Leave, Military Leave, Professional Leave, Sick Leave, and paid Holidays are as per the House Officers and the University Regulation and Benefit Manual. Also, fellows may be entitled to unpaid Family Leave, with the understanding that they may be required to complete missed rotations.

### **III. Unplanned Absences**

It is the responsibility of each fellow to notify their teaching faculty, and the Fellowship Office as soon as possible in the event of an unplanned absence (such as: illness/injury/family emergency).

### **IV. Coverage While on Leave**

1. Fellows must identify the fellow or faculty who are providing coverage while they are on leave. This includes arranging coverage in conjunction with the other fellow and/or attendings for unplanned absences whenever possible. The fellow’s service, the UPC or VA

operator, all supervisors and the fellowship office must be informed of who is covering for the fellow.

2. All patients that the fellow has clinical responsibility for must be covered.
3. Patients being followed individually by the fellow must have identified coverage (e.g., continuity patients, psychotherapy patients, groups).

## **PROFESSIONAL ETHICS**

### **I. Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry**

Fellows and faculty are expected to be familiar with and abide by the current edition of the Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry. A copy of this text is attached at the end of the handbook. These ethical principles were developed primarily for the benefit of the patient but also reflect a professional's duty to self, colleagues and to society at large.

### **II. Exploitation**

Physicians must not exploit patients for private advantage and therefore must be especially careful whenever they have more than one role or relationship with a patient. For the psychiatrist, these boundaries are especially important. When you are the treating physician, conflicts may arise if you are also the research investigator, a personal friend, a colleague, an employer or a customer. All such multiple relationships must be carefully examined in supervision. Having a sexual relationship with your patient is expressly forbidden and in the State of New Mexico is a criminal offense.

### **III. Personal Relationships**

Personal relationships between supervising psychiatrists and fellows must also be carefully examined. Because of the inequality of power and status inherent in such relationships, fellows are potentially vulnerable professionally and personally. Intimate relationships arising in training settings may cause harm to the fellow's professional development. Whenever such multi-role relationships arise they should be discussed with another appropriate supervisor and the fellowship training director.

## **RELATIONSHIP BETWEEN FELLOWS AND PHARMACEUTICAL SALES REPRESENTATIVES**

The policy is the same as that for the UNM HSC, included below:

## **Policy for Managing Private Healthcare Industry\* (PHCI) Interactions at the UNM HSC Clinical Care and Educational Missions\*\***

**Approved by the SOM Committee of Chairs January 23, 2008.**

**Approved by the COP Dean's Executive Leadership Committee, February 25, 2008**

**Approved by the Dean, CON, February 12, 2008**

**Approved by the CEO UNMH, March 10, 2008.**

### **Goals to be achieved for a Policy to guide the interactions of the HSC with PHCI.**

- To maintain the highest standards of integrity, honesty and critical assessment in all relationships of the HSC, its faculty, staff and trainees with the private healthcare industry
- To manage the potential for adverse private healthcare industry influence on clinical decision-making and educational activities at the UNM HSC.
- To avoid the appearance of inappropriate access of commercial interests to UNM healthcare providers and trainees.
- To facilitate productive, mutually beneficial relationships between our healthcare providers and trainees with the private healthcare industry, including education our trainees and healthcare providers in issues of importance in these relationships.

\*For the purpose of this Policy, Private Health Care Industry (PHCI) is defined as establishments engaged in one or more of the following: (1) manufacturing biological and medical products, including drugs and devices; (2) isolating active medicinal principals from botanical drugs and herbs; and (3) manufacturing pharmaceutical products intended for internal and external administration. This definition explicitly excludes drug wholesalers, pharmacies (corporate, independent, institutional or any other professional practice setting), or pharmacy benefit management companies.

\*\*Other Regent approved policies are in place to guide UNM HSC interactions related to the research mission.

### **1. Provision of Compensation or Gifts from Industry to HSC Faculty, Staff, and Trainees**

- a. UNMHSC faculty, staff and trainees may not accept any form of personal gift from PHCI or its representatives anywhere on the UNM HSC campus. Display of any item bearing industry logos, such as pens, pads, hats, shirts is similarly prohibited on the UNM HSC campus.
- b. Beginning January, 2011, meals funded by PHCI cannot be provided on the UNM HSC campus. In the transition, departments and divisions will reduce their dependence on PHCI funding by at least 33% in each of the three years.
- c. HSC faculty, staff and trainees may accept only fair market compensation for specific, legitimate services provided by him or her to a PHCI. Payment must be commensurate with time and effort.

d. HSC faculty, staff and trainees may not accept compensation or gifts for listening to a sales pitch (e.g., detailing) by an industry representative.

e. HSC faculty, staff and trainees who are simply attending a continuing education (e.g., CME) or other instructional activity and are not speaking or otherwise actively participating or presenting at the meeting, should not accept direct compensation from PHCI either for attending or defraying costs related to attending the meeting.

f. HSC health care providers must conscientiously and actively divorce clinical care decisions (including referrals, and diagnostic or therapeutic management) from any potential or actual benefits accrued or expected from any PHCI (including but not limited to personal gifts, research funding, scholarships for continuing education attendance, consulting agreements, and the like).

g. HSC faculty or staff who are involved in institutional decisions concerning the purchase or approval of medications or equipment, or the negotiation of other contractual relationships with industry, must disclose any relevant financial interest (e.g., equity ownership, compensated positions on advisory boards, a paid consultancy or other forms of compensated relationship) in an industry that might benefit from the institutional decision. Where actual or potential conflict of interest exists, the individual should recuse him/herself from the process. This provision is not intended to preclude the indirect ownership, through mutual funds or other investment vehicles, of equities in publicly traded pharmaceutical companies by UNM faculty nor does it require declaring a potential or real COI for holding mutual funds as described herein.

h. HSC health care providers may not receive any form of compensation for changing a patient's prescription.

i. PHCI representatives are restricted to certain areas of the hospital, and must follow existing UNM Hospitals (UNMH) policies concerning these restrictions. Therefore, HSC faculty, staff and trainees must meet with pharmaceutical representatives only in approved areas.

## **2. Provision of Scholarships and Other Funds to HSC Trainees**

HSC faculty, staff and trainees should ensure that support of HSC trainees by industry through funding mechanisms such as scholarships, reimbursement of travel expenses, or other non-research funding in support of scholarship or training are free of any actual or potential conflict of interest. Industry funding of trainees should comply with all of the following:

- a. The trainee is selected by the HSC department, program, or section.
- b. The funds are provided to the department rather than directly to the trainee.
- c. The department, section or program has determined that the conference or training has educational merit.

- d. The recipient of the funds is not subject to any implicit or explicit *quid pro quo* (i.e., “no strings are attached”).
- e. The donors may not label donated objects with industry logos or information.

This Policy is not intended to preclude industry support for HSC faculty or staff to travel to evaluate major clinical equipment for prospective acquisition by a program, department, or other UNM entity.

### **3. Provision of Free Drug Samples to HSC Health Care Providers**

The use of drug samples at UNMH is governed by specific policies established by the Pharmacy department and approved by the Medical Executive Committee. In general these policies include the following:

- a. Drug samples are not allowed for inpatient use.
- b. Samples are allowed for outpatient use with specific requirements for dispensing, storage and documentation. If the use of samples is contemplated, the prescribing service or physician must contact the Executive Director of Pharmacy Services for review of the indication and procedures to be followed. In some cases approval of the Pharmacy and Therapeutics Committee may be required.
- c. Free drug samples may never be sold.
- d. Free drug samples should not be used by HSC health care providers for themselves or family members.

### **4. Industry Support for Educational Events on the UNM Health Sciences Center Campus**

HSC faculty, staff, and trainees should adhere to the policies for continuing education established within each discipline (e.g., ACCME for the School of Medicine, ACPE for College of Pharmacy, etc.).

### **5. Policies for Delivering Industry-Sponsored Lectures or Participating in Legitimate Conferences and Meetings off the UNM HSC Campus**

Clinical meetings and scientific meetings sponsored by professional societies frequently derive a portion of their support from industry. Industry sponsorship generally takes one of two general forms and different standards apply in each case.

The policies below that address legitimate conference/meeting activities that relate to the subsidies and payments and that encompass scholarships or other funds to allow for trainee attendance should serve as the policies for these types of activities. First, industry may partially sponsor meetings run by professional societies. HSC faculty and staff are expected to participate

in meetings of professional societies as part of their continuing education (e.g., CE) and professional obligations. Nonetheless, faculty should be aware of the potential influence of industry on these meetings and attentive to the policies set forth below in evaluating whether and how to attend or participate in these meetings. A second type of meeting is fully sponsored and run by industry. The following policies apply in that case. These policies apply to all lectures, meetings, and related publications sponsored directly by industry or by intermediate educational companies subsidized by industry.

HSC faculty, staff and trainees should actively participate (e.g., by giving a lecture, organizing the meeting) in such meetings or lectures only if:

- a. financial support by industry is fully disclosed at the meeting by the sponsor;
- b. the meeting or lecture's content, including slides and written materials, are prepared or determined by the HSC faculty, staff and/or trainee;
- c. the lecturer is expected to provide a balanced assessment of therapeutic options and should promote objective scientific and educational activities and discourse;
- d. the HSC faculty, staff or trainee is not required by the company sponsor to accept advice or services concerning teachers, authors or other educational matters including content as a condition of the sponsor's contribution of funds or services;
- e. attendees in the audience are not directly compensated or otherwise materially rewarded for attendance;
- f. the HSC faculty, staff or trainee receives compensation only for the services provided and the compensation is reasonable;
- g. time spent in preparing and delivering the lectures does not impair the HSC faculty, staff or trainee's ability to fulfill departmental responsibilities;
- h. the lecturer explicitly describes all his or her relevant financial interests to the audience; and
- i. the lecturer makes clear to the audience that the content of the lecture reflects the views of the lecturer only and not the University of New Mexico HSC.

Note: HSC faculty and staff should not facilitate the participation of HSC trainees in industry-sponsored events that fail to comply with these standards.

## **6. Disclosure of Relationships with Industry**

- a. HSC faculty, staff and trainees should disclose the existence of their *relevant* financial interests, past and existing, (e.g., grants and sponsored research, compensation from consulting, speaker's bureaus, advisory boards; investments and ownership interests) to

journal editors (as required by the publisher in manuscripts submitted for publication), and to audiences at lectures or presentations.

b. HSC faculty are required to provide specific written information on financial interests related to their research at UNM in compliance with Regent approved University regulations. Currently there is no policy in place at UNM requiring similar disclosures for educational and training activities. HSC faculty, staff and trainees should adhere to the policy in 6a for these activities.

c. HSC faculty, staff and trainees must disclose their potential conflicts of interest related to institutional deliberations and recuse themselves when participating in deliberations in which he or she has an actual or potential conflict of interest.

d. HSC faculty with supervisory responsibilities for trainees or staff must ensure that conflicts or potential conflicts of interest do not affect the supervision or educational process.

Note: Individual departments, colleges, SOM, hospitals, centers or institutes may implement more restrictive policies than what are contained in these HSC Policies.

## **7. Exceptions**

Faculty or departments seeking exceptions to the above policy may petition the Executive Vice Pfellow for Health Sciences, who will convene a three-person ad hoc committee to review the request and advise the Executive Vice Pfellow, whose decision will be final. Requests should clearly identify how the benefits resulting from the exception outweigh the risks, perceived or real.

## **GOVERNANCE OF PROGRAM**

A. Governance of the UNM School of Medicine's Geriatric Psychiatry Fellowship Program rests ultimately with the Chairman of the Department. Committees which are directly involved in the development and implementation of the Fellowship Training Program include the Residency Training Committee.

B. Relationship with the Department of Psychiatry

The Fellowship Training Program is an integral part of the Department of Psychiatry. One of the main tasks of the Department faculty is the training of postgraduate physicians in the specialty of psychiatry.

The responsibility for the curriculum of the fellows resides with the faculty of the Department of Psychiatry, Geriatric Psychiatry Programs.

The Director of Fellowship Training is a member of the Residency Training Committee. This committee is responsible for the administration of the training.. Major changes in

policy or in the program will be presented to the Chairman's Advisory Committee (the "K+ Committee") for discussion and recommendation for approval by the Chairman of the Department.

### C. Relationship with the University Psychiatric Center (UPC)

The UPC is a component of the UNM Health Sciences Center and is one of the clinical programs utilized by the Department of Psychiatry for fellowship training. The functions and needs of the Fellowship Programs and UPC constructively complement each other. To enhance a smooth interface between training and clinical care, the service chiefs from UPC are appointed to the Residency Training and Competency Committee, while faculty active in training are on a variety of UPC administrative committees.

Fellows function as the principal providers of care in a variety of settings at UPC. Fellows are assigned to inpatient services, , community programs, , , specialty clinics and other elective service areas. They are granted admitting privileges by the Medical Staff. Faculty of the Department of Psychiatry who are assigned responsibilities at the various UPC clinical locations supervise the fellows' clinical work. Fellows are required to attend educational activities that the Fellowship Program organizes (e.g., seminars, special lectures and meetings). They may be excused when in the judgment of the fellow or his/her supervisor a clinical emergency requires continued patient care on site. Fellows are expected to provide high quality psychiatric care under the supervision of faculty who are responsible for all care provided. Fellows are expected to maintain adequate medical records, act at all times in an appropriate professional manner and carry out all of their clinical responsibilities in a timely and ethical manner.

**Governance:** While working on rotation at UPC the chief of each service is responsible for the assignment of clinical duties to the fellows. In cases in which a chief of service is not identified (e.g., electives), the Director of Fellowship Training will assign an appropriate individual. Education and training of the fellows remains the primary responsibility of the Director of Fellowship Training. Problems in the clinical functioning of the fellows will be directed to the Chief of Service and then, as necessary, to the Associate Director, Psychiatry Training Program for UPC or the Director of Fellowship Training. Supervisors at UPC are expected to complete timely evaluations of fellows assigned to their service.

### D. Relationship with the VA Medical Center Psychiatry Service

As a medical center with a psychiatric clinical commitment analogous to the UPC, the relationship of the service to the Fellowship Training Program is similar to the one described above for the UPC.

**Governance:** While working on rotation in the VA, the Chief of the Service is responsible for assignment of clinical duties of the fellows. Training of the fellow remains the responsibility of the Director of Fellowship Training, who can assign training

in full or in part to the Associate Director, Psychiatry Training Program for the VA, Chief of the Service, and to other faculty working at the VA.

#### E. Relationship to the University Hospital and VA Medical Center - Consultation and Non-Psychiatric Services

Fellows rotate through the consultation services of UH and VA during their training in liaison and consultation clinical work.

There are other occasional involvements of fellows in the Medical School (e.g., fellows who participate in research work with faculty members in other departments, and in medical student teaching activities).

Governance: While working on a rotation in another department, the Chief of the Service is responsible for assignment of the fellow. Training of the fellow is the responsibility of the Director of Fellowship Training who can assign training in full or in part to the Chief of the Service for the duration of the training.

F. The Residency Training Committee is a standing committee of the Department with members involved in the major clinical enterprises of the department, and faculty selected by the Director of Residency Training. It is comprised of all members of the Steering Committee, representatives from each year of training, at least one representative from each of the following areas: VA, UPC, and Child Division, and other members as deemed appropriate. The RTC meets on the first and third Tuesdays of each month in the Department. It oversees the major activities of the program, implements and develops policy for the training program. The Committee exchanges information and helps to resolve conflicting needs of participating institutions and fellows, and makes recommendations to the Chairman's Advisory Committee.

G. The Director of Fellowship Training is directly assisted by the Geriatric Psychiatry Faculty Group, which is made up of the following members: Director of Fellowship Training, Associate Directors of Fellowship Training, and other key Geriatric Psychiatry Faculty, Fellow(s) and the Fellowship Coordinator. This committee meets every Monday from 1:00pm-2pm in the Roadrunner Room at the University Psychiatric Center. It deals primarily with the day-to-day running of the fellowship and is involved with matters such as scheduling, budgeting, and evaluating fellows' performance

H. The composition of the Residency Training Committee and the Fellowship Steering Committee is determined at the beginning of each academic year (July).

### **RESPONSIBILITIES OF FELLOWSHIP PROGRAM STAFF**

#### ***Director of Fellowship Training***

- Carries out functions necessary to maintain accreditation of the fellowship by the Accreditation Council for Graduate Medical Education (ACGME), including overseeing

preparation of accreditation reports as dictated by the length of the current accreditation cycle.

- Recruits and selects fellows.
- Assures that requirements of the fellowship are in accordance with ACGME and the American Board of Psychiatry & Neurology (ABPN) guidelines. Ensures that all graduating fellows are adequately trained and eligible to apply for their Board examinations.
- Oversees coordination of evaluations of fellows by clinical supervisors and by oral and written examinations. Assists fellows in meeting fellowship requirements or, if they are unable to meet these requirements, assists them in seeking a career outside geriatric psychiatry.
- Oversees preparation and coordination of schedules of fellows' rotations, seminars, and other training activities. Designs a comprehensive curriculum, which includes reading, formal seminars, clinical work and any other appropriate educational activities to be approved by the Chairman and the Residency Training and Competency Committee.
- Coordinates and monitors all policies for all fellows.
- Oversees preparation of a budget (annually) for fellows' stipends and for other educational expenses (travel to meetings, retreats, examination fees).
- Is a member of the Residency Training and Competency Committee. Confers regularly with supervisors of clinical rotations and supervisors of psychotherapy. Assists faculty in doing the work of clinical supervision, fellow evaluation, and seminar teaching. Meets regularly with the Departmental Chairman, the Vice Chair for Education, and the Fellowship Coordinator in order to ensure the smooth running of the program.
- With the help of the coordinator, orients fellows to the program, the tasks of each rotation, and to each year of work. Meets biannually with fellows for evaluation and career counseling. Meets regularly with fellows. Ascertains that fellows are actively participating in the ongoing evaluation and further development of the program.
- Coordinates contractual agreements with institutions and agencies which provide training sites for fellows--UPC, UH, VAMC, Manzano del Sol and other miscellaneous elective sites.
- Responds to present and former fellows' requests for letters of recommendation. Oversees maintenance of adequate records on each fellow.
- Facilitates the graduation, transfer, or termination of fellows from the program.
- Approves and monitors annual leave, sick leave, and educational leave taken by fellows.

- Evaluates periodically all aspects of fellowship training, assessing strengths and weaknesses of the program.
- Assists each fellow in working to his or her maximum potential while learning to become a psychiatrist. Responds to the particular training needs of each fellow.

### ***Fellowship Coordinator***

- Attends and participates in meetings of the Residency Training, Competency and Quality Assurance Committee.
- Prepares the annual stipend budget for the Fellowship Program. Prepares contract requests for all fellows.
- Prepares rotation and seminar schedules.
- Distributes evaluations for fellows. Distributes forms for fellows to evaluate the fellowship program and prepares abstracts of these reports.
- Initiates and composes correspondence.
- Coordinates events with out-of-town consultants.
- Maintains fellowship files.
- Sends out application materials to applicants, arranges interviews, assists with position offers
- Assists with planning graduation ceremony and orders fellowship certificates.
- Prepares monthly billing document for the Office of Graduate Medical Education.
- Assists the Director in the day-to-day operations of the fellowship program.

## **ADDENDA**

### **JOB DESCRIPTION AND PERFORMANCE EXPECTATIONS**

#### **Fellow Physician, Department of Psychiatry, University of New Mexico School of Medicine**

This job description is not and should not be considered an all-inclusive list of responsibilities, duties, and skills required, but rather a description of minimum performance expectations for fellows in training in the Department of Psychiatry at the University of New Mexico. This description is in addition to the General Fellow Job Description for the University Of New Mexico School Of Medicine, and is in accord with ACGME competencies for post-graduate training in psychiatry.

## **Responsibilities**

The fellow physician will:

- Conduct appropriate history and physical examinations, including the Mental Status Examination. This performance requires that the physician consistently collects relevant data with essential positives and negatives, sufficient to support diagnosis.
- Demonstrate appropriate interviewing skills. Successful performance will include conducting complete interviews. The fellow physician will solicit data for all elements of history and physical, including pertinent positives and negatives.
- Make appropriate oral presentations. These should be complete, organized presentations that include all basic information in standard format. To demonstrate an understanding of the history and disease processes, there should be coherent flow and organization.
- Generate appropriate diagnoses and formulations for their patients. This will require that the fellow independently identifies major problems, generates a reasonable working diagnosis, and a differential diagnosis list that includes key alternative diagnoses. The fellow will be able to construct an accurate multi-axial diagnosis and rudimentary biopsychosociocultural formulation. There should be an ability to integrate psychodynamic formulations as appropriate.
- Generate a sound treatment plan for their patients. This plan should be organized around problems. A sound treatment plan identifies appropriate treatment options and weighs choices to create a realistic multi-modal, biopsychosocial, multi-disciplinary plan. The fellow physician involves patient and family in planning. There should be measurable goals in the plan, and the plan addresses safety issues.
- Demonstrate effective patient management. The fellow physician assumes significant responsibility for patient management, and provides appropriate, high quality care. Effective management includes sound clinical judgment, appropriate use of tests, and safe performance of procedures. These procedures will be conducted with appropriate supervision, and may include the use of psychiatric rating scales, ECT, and other procedures consistent with emergency, inpatient, and outpatient psychiatric care. The fellow physician will recognize and handle emergencies competently. Patients will be reevaluated regularly, and treatment plans will be modified according to findings, with assistance, as needed.
- Demonstrate an adequate psychiatric and medical fund of knowledge. There must also be a consistent demonstration of application of basic science and clinical principles to patient care. The fellow physician will follow up on suggested readings, and attempt to apply acquired knowledge to patient care.
- Engage in practice-based learning and improvement. This is demonstrated with a growing habit of self-assessment and disciplined self-directed learning. The fellow physician will show at least novice-level information searching and evidence-based medicine skills. The fellow physician will accept feedback without defensiveness and will use this feedback to guide adaptive change. The fellow physician will facilitate learning of others, including other medical professionals and medical students. The fellow physician will be active in seminar participation.

- Create and sustain a therapeutic and ethically sound relationship with patients and their families. This relationship will include effective communication, caring and respectful behaviors that supersede self-interest. The fellow physician will counsel and educate patients and their families effectively. The fellow physician will recognize and maintain appropriate professional boundaries.
- Generate effective professional relationship with colleagues, including faculty, fellow fellows, medical students, and social work and nursing students. This will include an ability to work effectively with associates in a way that invites mutual respect. The fellow physician will show awareness of roles of others, and will be regarded as accountable by others.
- Engage in appropriate professional work habits. This will include satisfactory and punctual attendance to scheduled educational and clinical activities, and demonstration of the ability to complete work within normal duty hours. The fellow physician will be available when needed, and respond to pages or telephone calls in a reliable and timely manner. The fellow physician will keep records that are complete, concise, well-written, and timely. The medical record will illustrate progression of care, and will include basic elements to satisfy billing, legal, and patient care needs. The fellow physician will be compliant with all medical record requirements.
- Engage in ethical decision-making and honesty. This will include application of professional ethical standards to patient care. The fellow will be aware of and address both ethical and legal issues that affect a patient's care
- Display professionally appropriate cultural sensitivity. The fellow physician will demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities.
- Display professionally appropriate learning behaviors. This will include working at expected level of independence, recognition of limits to knowledge or skill, recognition of errors, and seeking help and supervision when needed. Reading assignments will be completed reliably, and the fellow physician will demonstrate some growth and initiative in learning behaviors. The fellow will accept feedback around learning without defensiveness.
- Appreciate the implications of systems-based practice, including appreciation of the organization of mental health care systems, and will plan individual patients' care accordingly. The fellow physician will practice cost-effective medicine, while advocating for quality patient care with case managers, utilization review personnel, etc. The fellow physician will assist patients and families in dealing with system complexities.
- Show evidence of progressive improvements in their ability to care for patients and to provide supervision for learners. Provision of care will include care in out-patient, in-patient, emergency, and consult-liaison settings, but may not be limited to these settings. The fellow physician may have responsibility to supervise a variety of learners, medical students, students in other health care professions, and residents

## **American Psychiatric Association**

### **The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry**

#### **2006 Edition**

Link to AMA Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatry: [http://www.psych.org/psych\\_pract/ethics/ppaethics.pdf](http://www.psych.org/psych_pract/ethics/ppaethics.pdf)

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The Principles of Medical Ethics 2006 Edition

(Previous editions 1973, 1978, 1981, 1984, 1985, 1989, 1992, 1993, 1995, 1995 Revised, 1998, 2001, 2001 Revised)

*American Psychiatric Association, 1000 Wilson Boulevard #1825, Arlington, VA 22209*

In 1973, the American Psychiatric Association (APA) published the first edition of *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*. Subsequently, revisions were published as the APA Board of Trustees and the APA Assembly approved additional annotations. In July of 1980, the American Medical Association (AMA) approved a new version of the *Principles of Medical Ethics* (the first revision since 1957), and the APA Ethics Committee incorporated many of its annotations into the new *Principles*, which resulted in the 1981 edition and subsequent revisions. This version includes changes to the *Principles* approved by the AMA in 2001.

#### Foreword

All Physicians should practice in accordance with the medical code of ethics set forth in the *Principles of Medical Ethics* of the American Medical Association. An up-to-date expression and elaboration of these statements is found in the Opinions and Reports of the Council on Ethical and Judicial Affairs of the American Medical Association. Psychiatrists are strongly advised to be familiar with these documents.

However, these general guidelines have sometimes been difficult to interpret for psychiatry, so further annotations to the basic principles are offered in this document. While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice, even

though the basic principles are the same. The annotations are not designed as absolutes and will be revised from time to time so as to be applicable to current practices and problems.

Following are the *AMA Principles of Medical Ethics*, printed in their entirety, and then each principle printed separately along with an annotation especially applicable to psychiatry.

### **Principles of Medical Ethics American Medical Association**

#### **Preamble**

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following *Principles* adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

*Section 1* A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

*Section 2* A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

*Section 3* A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

*Section 4* A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

*Section 5* A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

*Section 6* A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

*Section 7* A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

*Section 8* A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

*Section 9* A physician shall support access to medical care for all people.

### **Principles with Annotations**

Following are each of the AMA *Principles of Medical Ethics* printed separately along with annotations especially applicable to psychiatry.

#### **Preamble**

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

#### *Section 1*

*A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.*

1. A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor–patient relationship, and thus upon the well-being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.
2. A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.
3. In accord with the requirements of law and accepted medical practice, it is ethical for a physician to submit his or her work to peer review and to the ultimate authority of the medical staff executive body and the hospital administration and its governing body. In case of dispute, the ethical psychiatrist has the following steps available:
  - a. Seek appeal from the medical staff decision to a joint conference committee, including members of the medical staff executive committee and the executive committee of the governing board. At this appeal, the ethical psychiatrist could request that outside opinions be considered.
  - b. Appeal to the governing body itself.
  - c. Appeal to state agencies regulating licensure of hospitals if, in the particular state, they concern themselves with matters of professional competency and quality of care.
  - d. Attempt to educate colleagues through development of research projects and data and presentations at professional meetings and in professional journals.

e. Seek redress in local courts, perhaps through an enjoining injunction against the governing body.

f. Public education as carried out by an ethical psychiatrist would not utilize appeals based solely upon emotion, but would be presented in a professional way and without any potential exploitation of patients through testimonials.

4. A psychiatrist should not be a participant in a legally authorized execution.

## *Section 2*

*A physician shall uphold the standards of professionalism, be honest in all professional interactions and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.*

1. The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control. Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical.

2. The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.

3. A psychiatrist who regularly practices outside his or her area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.

4. Special consideration should be given to those psychiatrists who, because of mental illness, jeopardize the welfare of their patients and their own reputations and practices. It is ethical, even encouraged, for another psychiatrist to intercede in such situations.

5. Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.

6. It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of the specific contractual agreement with the patient. Charging for a missed appointment or for one not canceled 24 hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make such a charge. The practice,

however, should be resorted to infrequently and always with the utmost consideration for the patient and his or her circumstances.

7. An arrangement in which a psychiatrist provides supervision or administration to other physicians or nonmedical persons for a percentage of their fees or gross income is not acceptable; this would constitute fee splitting. In a team of practitioners, or a multidisciplinary team, it is ethical for the psychiatrist to receive income for administration, research, education, or consultation. This should be based on a mutually agreed-upon and set fee or salary, open to renegotiation when a change in the time demand occurs. (See also Section 5, Annotations 2, 3, and 4.)

### *Section 3*

*A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.*

1. It would seem self-evident that a psychiatrist who is a law-breaker might be ethically unsuited to practice his or her profession. When such illegal activities bear directly upon his or her practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his or her patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine.

2. Where not specifically prohibited by local laws governing medical practice, the practice of acupuncture by a psychiatrist is not unethical per se. The psychiatrist should have professional competence in the use of acupuncture. Or, if he or she is supervising the use of acupuncture by nonmedical individuals, he or she should provide proper medical supervision. (See also Section 5, Annotations 3 and 4.)

### *Section 4*

*A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.*

1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he or she must be circumspect in the information that he or she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

2. A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the students' explicit permission.
3. Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.
4. The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his or her duty of confidentiality.
5. Ethically, the psychiatrist may disclose only that information which is relevant to a given situation. He or she should avoid offering speculation as fact. Sensitive information such as an individual's sexual orientation or fantasy material is usually unnecessary.
6. Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.
7. Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time, the psychiatrist must assure the minor proper confidentiality.
8. When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient."
9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients, he or she may comply or he/ she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.
10. With regard for the person's dignity and privacy and with truly informed consent, it is ethical to present a patient to a scientific gathering if the confidentiality of the presentation is understood and accepted by the audience.

11. It is ethical to present a patient or former patient to a public gathering or to the news media only if the patient is fully informed of enduring loss of confidentiality, is competent, and consents in writing without coercion.
12. When involved in funded research, the ethical psychiatrist will advise human subjects of the funding source, retain his or her freedom to reveal data and results, and follow all appropriate and current guidelines relative to human subject protection.
13. Ethical considerations in medical practice preclude the psychiatric evaluation of any person charged with criminal acts prior to access to, or availability of, legal counsel. The only exception is the rendering of care to the person for the sole purpose of medical treatment.
14. Sexual involvement between a faculty member or supervisor and a trainee or student, in those situations in which an abuse of power can occur, often takes advantage of inequalities in the working relationship and may be unethical because:
  - a. Any treatment of a patient being supervised may be deleteriously affected.
  - b. It may damage the trust relationship between teacher and student.
  - c. Teachers are important professional role models for their trainees and affect their trainees' future professional behavior.

#### *Section 5*

*A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.*

1. Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.
2. In the practice of his or her specialty, the psychiatrist consults, associates, collaborates, or integrates his or her work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health nurses, and the like. Furthermore, the nature of modern psychiatric practice extends his or her contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he or she is dealing is a recognized member of his or her own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he or she refers patients. Whenever he or she has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him/her.

3. When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he or she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if the psychiatrist allows himself/herself to be used as a figurehead.
4. In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment.
5. The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve, he or she may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.

#### *Section 6*

*A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.*

1. Physicians generally agree that the doctor-patient relationship is such a vital factor in effective treatment of the patient that preservation of optimal conditions for development of a sound working relationship between a doctor and his or her patient should take precedence over all other considerations. Professional courtesy may lead to poor psychiatric care for physicians and their families because of embarrassment over the lack of a complete give-and-take contract.
2. An ethical psychiatrist may refuse to provide psychiatric treatment to a person who, in the psychiatrist's opinion, cannot be diagnosed as having a mental illness amenable to psychiatric treatment.

#### *Section 7*

*A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.*

1. Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government. A psychiatrist should clarify whether he/ she speaks as an individual or as a representative of an organization. Furthermore, psychiatrists should avoid cloaking their public statements with the authority of the profession (e.g., "Psychiatrists know that \_\_\_\_\_").

## Recognition of fatigue

### Objective

- A decline in performance starts after about 15-16 hours of continued wakefulness
- The period of lowest alertness after being up all night is between 6am and 11am.
- Fatigue prompts wide-ranging neurobehavioral and cognitive deficits.
- As lapses of attention increase, alertness and vigilance become unstable.
- Cognitive slowing occurs, time pressure increases errors, and working memory declines.

### Subjective

- Falling asleep in conferences or on rounds
- Feeling restless and irritable with staff, colleagues, family, and friends
- Having to check your work repeatedly
- Having difficulty focusing on the care of your patients
- Feeling like you really just don't care

### Driving

- Signs of driving impairment due to fatigue
  - Trouble focusing on the road
  - Difficulty keeping your eyes open
  - Nodding
  - Yawning repeatedly
  - Drifting from your lane, missing signs or exits
  - Not remembering driving the last few miles
  - Closing your eyes at stoplights
- How to avoid driving impairment due to fatigue
  - Get a ride home or take a taxi.
  - Take a 30 minute to one hour nap.
  - STOP DRIVING if you have driving impairment due to fatigue.
  - Pull off the road at a safe place, take a short nap.

## Strategies to Decrease and Prevent Fatigue

### Healthy Sleep Habits

- Adequate sleep *before* call night / moonlighting (at least 7 hours).
  - DON'T START CALL WITH A SLEEP DEFICIT
- Recovery from sleep loss takes **2 nights of extended sleep** to restore baseline alertness.
  - Recovery sleep generally has a higher percentage of deep sleep.
- Sleep Hygiene isn't just for patients
  - Have a regular sleep schedule.
  - Follow a regular routine prior to retiring for the night.
  - Engage in some relaxing activity before sleep.

- Protect your sleep time.
- Sleeping environment:
  - Cooler temperature
  - Dark (eye shades, room darkening shades)
  - Quiet (unplug phone, turn off pager, use ear plugs, white noise machine)
  - Avoid hunger or heavy meals prior to retiring.
  - The older you get, the more caffeine and other methyl xanthenes affect you.
    - Less time in deep sleep (so easier to be roused out of sleep)
    - Slowed metabolism of methyl xanthenes
    - YOU'RE NOT A MEDICAL STUDENT ANYMORE
- Exercise helps, but vigorous exercise 3-4 hours before retiring can make it difficult to fall asleep.
- DON'T LIE AWAKE IN BED! If you can't sleep after a period of 15 minutes, get up, do something quiet and relaxing until you are tired, then return to bed. If you have become used to staying in awake in bed, you may need to repeat this many times until you re-train yourself.

## Department of Psychiatry Fellow and Faculty Duty Hours Contract

### Background

The **Accreditation Council for Graduate Medical Education (ACGME)** released new rules on duty hours for fellows in July of 2007. Our medical school now requires that all training programs adhere to these new rules, and that all faculty, residents, and fellows will commit to honoring the duty hour requirements.

The new rules are explicit and unambiguous, and compliance is not conceptually difficult. The new rules require that no fellow or fellow will work more than 80 hours per week, averaged over a 4 week period. Call cannot exceed 24 hours, with no more than 6 additional hours for didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical care. After 24 hours of continuous duty on-call, residents and fellows cannot accept new patients, and this restriction on accepting new patients includes clinic, consult, emergency, and inpatient settings. There must be at least 10 hours between duty periods, and fellows and fellows must have at least one day out of 7 with no clinical responsibilities, averaged over a 4 week period

Moonlighting is not considered call, and time spent moonlighting does not count toward the 30 hour and 10 hour rules. However, all moonlighting does count toward the 80 hour per week rule (averaged over 4 weeks).

The duty hour restriction does not apply to purely educational out of hospital activities like reading, research, licensing exam preparation, or manuscript preparation away from the duty site.

### Responsibilities

It is the responsibility of residents and fellows to notify their clinical supervisor about their post-call status in each instance that they are post call. It is the responsibility of the supervisor to insure that he or she knows when the fellows they supervise are post-call, that the post-call resident or fellow is free of clinical and administrative duties by the end of their 30 hour limit, and that they are assigned no new patients after 24 hours of continuous duty. In the event that a resident or fellow works more than 14 continuous hours on a non-call work day, the start of the next day at that clinical site should be modified so that there are at least 10 hours between shifts. Given the diversity of our training sites, it is left to each site to implement the monitoring and enforcement system that best fits their needs. Fellows are also responsible for entering duty hours on a weekly basis, and these duty hours will be monitored each week.

We stress that the duty hour restrictions described above are not guidelines, but rules that must be rigidly followed in every case. All faculty who supervise fellows, and all fellows, must agree to these restrictions and signify their agreement by signing this form.

When a fellow encounters problems with ancillary staff or faculty that will impede the fellow's adherence with duty hour rules, they should contact the Fellowship Program Director, Vice-Chair for Education, or the Fellowship Coordinator, who will resolve the problem.

Alternatively, if the fellow does not feel safe from retaliation or retribution by working through

the Education Office, that fellow can notify the GME Office, or call the Compliance Hotline (272-2588).

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Signature

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Print Name

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Date

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