University of New Mexico
School of Medicine

Department of Psychiatry

Addiction Psychiatry Fellowship
Training

Handbook

2011-2012
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**Mission Statement**

The mission of the Addiction psychiatry fellowship-training program at the University of New Mexico is to provide additional training in the subspecialty of Addiction psychiatry to residents who have successfully completed a four-year residency in Psychiatry. The fellow completing the one-year fellowship should develop the clinical skills, judgment, demeanor, and professional ethics with a level of scholarship and critical thought necessary to provide the highest quality of patient care to patients with addictive disorders. The training program should serve as a resource for the state of New Mexico for the management of Addiction problems of all types. The training program should serve a pivotal role in the education of medical and other health care professional students and practicing physicians in the state concerning mental health care of the Addiction patient.

**Mission Statement - University of New Mexico (UNM)**

The University will engage students, faculty, and staff in its comprehensive educational, research, and service programs. UNM will provide students the values, habits of mind, knowledge, and skills that they need to be enlightened citizens, to contribute to the state and national economies, and to lead satisfying lives. Faculty, staff, and students create, apply, and disseminate new knowledge and creative works; they provide services that enhance New Mexicans’ quality of life and promote economic development; and they advance our understanding of the world, its peoples, and cultures. Building on its educational, research, and creative resources, the University provides services directly to the City and State, including health care, social services, policy studies, commercialization of inventions, and cultural events.

**Overview**

**Educational Principles**

Education is the primary function of the University of New Mexico Department of Psychiatry. The faculty strive to train our fellows as psychiatrists who will grow in the profession and practice as competent physicians and scientists. Graduates are prepared to assume the psychiatric care of patients and to support their medical colleagues and community, as well as to continue their lifelong learning in psychiatric medicine.

We value the unique talents and interests of the individual and seek diversity in the background, personal qualities and professional goals among our residents. This is consistent with the diversity of cultures within New Mexico. We offer fellows experience in the full range of knowledge, viewpoints, and practices current in psychiatry today. In the final year of training, we offer strong programmatic flexibility that allows the individual resident to deepen the areas of his or her specific interests.

Our program maintains a strong commitment to the biopsychosocial approach. The curriculum includes biological, psychological and cultural components. Clinical experiences offer opportunities to develop medical and psychotherapeutic skills. The cultural diversity of New Mexico equips the resident with a keen awareness and understanding of cultural influence on human behavior. Fellows learn to understand their own reactions to patients, to function on interdisciplinary teams, to appreciate the problems of their community, to teach medical colleagues and other providers, to review the medical literature critically, and to function in administrative capacities.
All graduates of the University of New Mexico program are fully qualified specialists who have developed competency in medical knowledge, systems-based practice, patient care, interpersonal communication, professionalism, and practice-based learning. Graduates are competent to do psychodynamic, cognitive-behavioral, short-term, supportive, and combined psychotherapies. They meet the highest professional standards and are well-prepared for examination by the American Board of Psychiatry and Neurology in Addiction Psychiatry. Our graduates move into private practice, community service, academic and research settings and are fully prepared for further training in any of the psychiatric subspecialties.

The Setting

New Mexico is one of the most beautiful and culturally rich regions in the United States. Our living history extends back long before the birth of the United States. Successive waves of immigration occurring over 1,000 years have brought together a number of cultures: the Pueblo people, the Navajo and Apache, the Spanish, the Euro-American and, most recently, the African and Asian Americans. Although these groups have influenced one another, they have not melded together. Psychiatrists and trainees at UNM are confronted daily with the varying concerns of traditional Native Americans, nuclear physicists, oil company executives, members of counter-cultural communities, Hispanic Americans, the wealthy and the poor.

Albuquerque, named after the Spanish duke who granted the land for its establishment, is today a city of nearly half a million inhabitants and growing. Its increasingly metropolitan atmosphere is still strongly influenced by the independent frontier spirit of survival that dominates rural New Mexico. The city is the home of the University of New Mexico, which recently celebrated its centennial. The University traditionally derives its strengths from service to the State and from the rich local intellectual resources in anthropology and the fine arts. With the growth of the city and the development of large Federal technical installations in the State, such as the Sandia and Los Alamos National Laboratories, the Phillips Laboratory at Kirtland Air Force Base, and the White Sands Missile Range, has come an increasing emphasis in the University upon engineering, the physical sciences and business. The new administration of the University also has set as a goal the greater realization of our potential for the relationships with Latin America.

The School of Medicine is a newcomer upon this scene. It was established in 1964 and graduated its first class of 24 students in 1968. Today it remains relatively small and intimate, with approximately 73 students per class. The School of Medicine is consistently cited as one of the top ten programs in the United States in Family Medicine. Other major strengths lie in the areas of immunology, epidemiology, medical imaging, molecular biology, addictions, transfusion medicine, and trauma. In the face of limited resources in the state of New Mexico, a tradition of collaboration among departments and cross-disciplinary research and teaching has developed and continues to be deliberately encouraged.

The UNM School of Medicine has achieved national and international recognition for its innovative teaching of medical students. The School now holds one of only eight grants awarded nationwide by the Robert Wood Johnson Foundation to develop a new curriculum with increased emphasis on social medicine. This curriculum embraces the learning experiences of both medical students and residents. It focuses greater attention on ambulatory medicine, medical economics, epidemiology, and psychosocial aspects of medical practice. It more fully integrates basic science and clinical work.
Teaching Resources

The Department of Psychiatry has conducted a training program for residents since the inception of the Medical School. This program has grown from a single resident initially to about 35 at the present time. The faculty number more than 97, including some 85 psychiatrists, 12 psychologists, and a number of social workers, nurses, and others. In addition there is a large volunteer clinical faculty. Faculty interests are diversified, and all faculty participate in clinically based teaching for residents as well as didactic teaching. Currently, the Addiction psychiatry fellowship is one of five post residency training experiences. The other four training programs are Child and Adolescent, Geriatric, Psychosomatic Psychiatry and Research Psychiatry.

Clinical Resources

The University of New Mexico Mental Health Programs:

Located on the University of New Mexico Health Sciences Campus, the UNM Mental Health Programs are the primary teaching sites for our residents in psychiatry. These programs are all community based and provide services for about one third of the people in Bernalillo County seeking psychiatric care. The patient population is culturally and socially diverse.

All programs are under the clinical and educational supervision of the Acting Chairman of the Department of Psychiatry, George Nurnberg, M.D. The educational activities are directed by the Office of Education and Clinical Affairs which includes the Vice Chair of Educational and Academic Affairs, Jeffrey Katzman, M.D., Vice Chair for Clinical Affairs and Medical Director for the University Psychiatric Center, William J. Apfeldorf, M.D., the Director of Residency Training, Stephen Lewis, M.D., the Child and Adolescent Fellowship Director, Jeanne Bereiter, M.D., the Geriatric Fellowship Program Director, William J. Apfeldorf, M.D., Ph.D., and the Addiction Fellowship Program Director, Patrick Abbott, M.D.

The University Psychiatric Center

The UNM Psychiatric Center is an up-to-date, community based facility offering a full range of psychiatric treatment to adult patients. There are 45 inpatient beds, serving 30 general adult psychiatric patients and 15 geriatric patients

Albuquerque Veterans Administration Medical Center

Located four miles from the University of New Mexico Health Science Center, this tertiary care center relates to the Health Science Center as a Dean’s Committee Hospital. Teaching physicians are full members of the medical school faculty

The mental health services include a comprehensive trauma program, comprehensive substance abuse program with a residential facility, integrated psychiatry primary care program, behavioral medicine program, outpatient and inpatient consult liaison service.

Rural Psychiatry Programs

Rural psychiatry experiences are available in the fourth year. These ambulatory care settings are developed throughout New Mexico and offer clinical and community systems experience. The Department also networks with the Indian Health Service, the Las Vegas (New Mexico) State
hospital, public and private psychiatric clinics and hospitals throughout the state, a unique private practice group in Anchorage, Alaska, and the forensic psychiatry unit at the Bernalillo County Detention Center in Albuquerque. All are available for resident training.

**Milagro Clinic**

Milagro is a program for the treatment of substance abusing pregnant women. The program was initiated by the Department of Obstetrics and Gynecology in collaboration with the departments of Psychiatry, Pediatrics, and Public Health. It has been in existence for over twelve years and has been a valuable resource for the entire State of New Mexico. Dr. Abbott works with Dr. Rayburn, Chairman of the Department of Obstetrics and Gynecology, and Dr. Larry Leeman in the Department of Family Practice, who provides prenatal care for the women. Dr. Abbott provides psychiatric consultation and assists in managing patients on methadone and suboxone who often have complex addiction issues. Milagro has an active caseload of approximately 100 patients and between 10-20 patients who are on methadone maintenance and a handful on suboxone.

**UNMH Addictions and Substance Abuse Programs**

The ASAP clinic serves approximately 3,000 patients per year; 800 patients are currently in treatment. ASAP has an Opioid Treatment Program that serves over 400 patients on methadone or buprenorphine. We have a medical unit that provides assessments for all patients who start methadone, buprenorphine and who may need ambulatory detoxification from drugs of abuse. ASAP has 13 counselors and one case manager, who provide services to our patients through individual and group counseling sessions. Our clinical psychologist provides supervision to the counseling staff. In addition we have over six nurses who assist in the medical and dispensing clinic. In July of 2010 ASAP began a Primary Care Clinic that provides medical care for our substance abuse patients. In addition there is a Dual Diagnosis Clinic at ASAP. In this clinic fellows will supervise residents, medical students, Physician’s Assistant students and nursing staff in their care of patients with concurrent Severe Disabling Mental Illnesses and Substance Use Disorders.

**Graduate Education Committees**

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

The Addiction Psychiatry Fellowship Program at the University of New Mexico Psychiatric Center is administered by the Director of Addiction Psychiatry Training and a Addiction Psychiatry Training and Competency Committee consisting of all Department of Psychiatry faculty contributing to its teaching program. The Committee meets quarterly and as needed. This Committee formulates educational policy, oversees the curricula, and serves as the selection committee. The Director, with input from the Committee, ensures coordinated residency education among the facilities. The Committee reviews the performance of fellows and feedback from fellows quarterly, and reviews the curriculum in relation to the required competencies on a rotating basis (1-2 competencies per quarter). The 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. Membership is the same as the Addictions Division of the Department of Psychiatry, which meets monthly. This allows for easy scheduling of ad hoc meetings as needed. The Committee reports to the Chairman of the Department and the Vice Chair for Education.
As a component of the postgraduate educational training occurring in the Department of Psychiatry, the Addiction Psychiatry Fellowship Program participates in the administrative efforts of the Residency Program at the University of New Mexico. The Residency Training and Competency Committee formulates educational policy, oversees the curricula, and serves as the selection committee. The Director, with input from the Residency Training Committee ensures coordinated residency education with the facilities. The Residency Training and Competency Committee serves as the body to review special requests from residents such as moonlighting and leave. The Committee also serves as the review board in cases of grievances and performance problems. The Committee report to the Chairman of the Department. The current Addiction psychiatry fellows are invited to participate as full members of the committee, unless confidential material is to be discussed.
Faculty

Department of Psychiatry

Michael Bogenschutz, MD 272-8428
Vice Chair for Addiction Psychiatry and Clinical Research

Patrick Abbott, MD 925-2400
Medical Director for Addiction and Substance Abuse Programs
Program Director, Addiction Psychiatry Fellowship

Pamela Arenella, MD 272-2174
Medical Director, Dual Diagnosis Clinic

Claire Wilcox, MD 272-2174
Outpatient Psychiatrist

Snehal Bhatt, MD 925-2400
Outpatient Psychiatrist, ASAP

Daniel Duhigg, MD 951-1447 pgr
Outpatient Psychiatrist, UNM Pain Clinic

Marcia Harris, PhD 925-2400
Clinical Director, ASAP

Julia Bohan MD 925-2400
Outpatient Family Practice

Alyssa Forcehimes PhD 925-2399
Research Scientist

Albuquerque Veteran’s Administration Medical Center (VAMC)

Cynthia Geppert, MD, PhD 265-1711
Outpatient Psychiatrist

Department of Psychiatry Administration

George Nurnberg, M.D. 272-0518
Acting Chairman

Jeffrey Katzman, M.D. 272-5416
Vice Chair for Education and Academic Affairs

William Apfeldorf, M.D. 272-4712
Vice Chair for Clinical Services and Medical Director of University Psychiatric Center

Steve Lewis, M.D. 272-5417
Residency Training Director

Andrea Chapman 272-5002
Addiction Psychiatry Fellowship Program Coordinator
CLINICAL TRAINING EXPERIENCES

General Program and Fellowship Goals and Objectives
1. To provide additional experience and skills in the area of Addiction Psychiatry that will lead to the Certificate of Added Qualification in Addiction Psychiatry, American Boards of Psychiatry and Neurology.
2. To develop attitudes, skills and a body of relevant information, which will provide the best possible care for addicted patients and which support acceptable standards of medical and professional ethics. Facilitation of optimal use of 12-Step and other mutual-help programs by patients with substance use disorders.
3. Fellows in Addiction psychiatry will receive periodic evaluations and will be expected to show increasing expertise and competence in each evaluation period.
4. The above goals should be achieved by attaining the following objectives. Increasing expertise and competence will be judged on the following criteria:
   A. Ability to accumulate diagnostic data by history, physical examination, and laboratory tests specific to the nature of the particular addiction problem under consideration.
   B. Ability to decide on the methods of treatment with careful consideration of alternatives.
   C. Ability to inform the patient and family of recommendations for treatment and possible alternatives, risks, and complications.
   D. Ability to provide responsible and compassionate patient care with knowledge of the pathophysiology of addiction disorders.
   E. Ability to work with medical colleagues and an interdisciplinary team to provide appropriate and comprehensive care.
   F. Demonstration of increasing cognitive knowledge of all facets of addiction illness periodically evaluated by the program using methods constructed and administered by the faculty.
   G. Demonstration of increasing cognitive knowledge of the current literature as evidenced by discussion of patients and their problems in conferences and journal clubs and in day-to-day performance of duties.
   H. Demonstration of willingness to teach those at all levels of training below that of fellows, i.e., residents, medical students, interdisciplinary students, etc. This will also include sharing knowledge with faculty and other physicians.
   I. Demonstration of the ability and willingness to assist in contributing to the existing body of addiction literature by participating in research activities and developing scholarly descriptions of the results.
   J. Demonstration of adherence to appropriate moral, ethical, and professional standards.
   K. Residents will understand the benefits and limitations of 12-Step programs and other mutual-help programs, and will facilitate optimal utilization of these programs for their patients.

To achieve the goals and objectives of this fellowship, the following activities and experiences will be made available:
Rotations

<table>
<thead>
<tr>
<th>6 months</th>
<th>6 months</th>
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<tbody>
<tr>
<td>Outpatient Addiction Treatment (UNM Addiction and Substance Abuse Programs)</td>
<td>Outpatient Addiction Treatment (UNM Addiction and Substance Abuse Programs)</td>
</tr>
<tr>
<td>50%</td>
<td>10%</td>
</tr>
<tr>
<td>Inpatient Addiction Treatment and General Hospital Consultation (Albuquerque VA Hospital)</td>
<td>Inpatient Addiction Treatment and General Hospital Consultation (Albuquerque VA Hospital)</td>
</tr>
<tr>
<td>10%</td>
<td>50%</td>
</tr>
<tr>
<td>Dual Diagnosis Outpatient Treatment and Inpatient consultation (UNM Addiction and Substance Abuse Programs)</td>
<td>Dual Diagnosis Outpatient Treatment and Inpatient consultation (UNM Addiction and Substance Abuse Programs)</td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>HIV clinic (Truman Street Clinic)</td>
<td>CPH (Child/Adolescent Consult and Group)</td>
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<tr>
<td>10%</td>
<td>10%</td>
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<tr>
<td>Rural Outreach</td>
<td>Rural Outreach</td>
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<tr>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Research</td>
<td>Research</td>
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CLINICAL SERVICES

Residential Rehabilitation and IOP Addiction Psychiatry

Rotation Description:
This is a required rotation in the Addiction Psychiatry Fellowship and consists of 3 half days for 6 months in the STARR residential rehabilitation unit and the SUD Intensive Outpatient Mini Intensive Outpatient Treatment Program (MITP) of the New Mexico Veterans Affairs Health Care System (NMVAHCS). The NMVAHCS is a level 1 tertiary referral VA serving veteran from West Texas, Eastern Arizona, Southern Colorado and all of New Mexico. The STARR residential rehab has 24 beds and the Intensive Outpatient Program (IOP) averages 20 concurrent patients. The average length of stay in the STARR program is 3 months. The IOP consists of 4 weeks of 3 days/week group and individual therapy followed by 8 weeks of up to 2 days/week of groups and individual therapy with psychiatric assessments and medication management throughout.

Addiction fellows on this service assess and follow approximately 4-6 clients concurrently in the residential program and perform psychiatric diagnostic interviews on 2 new outpatients per week. They actively participate in treatment planning in the interdisciplinary treatment team in both residential rehab and IOP and are responsible for medication management, discussing the cases with the attending psychiatrist and developing comprehensive treatment plans.
The most common diagnoses fellows manage are PTSD, alcohol dependence and opiate dependence. The spectrum includes major mental disorders including MDD, BPAD, personality disorders, Anxiety Disorders as well as abuse and dependence on all major classes of drugs of abuse. In addition, the fellows run a therapy group of their choice for the residential rehab clients for which they receive supervision. Fellows participate in interdisciplinary treatment team meetings both in the residential rehab as well as the IOP and are exposed to the therapy groups in the IOP.

Each fellow is provided with a peer-reviewed journal articles related to the clients they encounter. The attending provides extensive supervision of the fellow during their rotation discussing all aspects of cases.

**Goal:**
The resident will acquire increased skill in the assessment and management of common substance use disorders and major mental disorders in the context of residential rehab and IOP programs and learn how to interact with the different members of interdisciplinary treatment teams in residential rehab and IOP settings.

**EDUCATION GOALS:**

<table>
<thead>
<tr>
<th>Fellows Will:</th>
<th>Competencies Addressed</th>
<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased knowledge of common substance use disorders in the residential and IOP setting and their interaction with other psychiatric disorders.</td>
<td>MK</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Increased knowledge of the liaisoning and interacting with other team members in residential rehab and IOP settings.</td>
<td>MK, PROF, ICS, SBP, PBL</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Increased knowledge of non-pharmacological modalities for substance abuse and major mental disorders that are employed in residential rehab and IOP, including seeking safety, prolonged exposure, CBT, and many others.</td>
<td>MK, PBL, SBP</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Increased knowledge of the use of psychotropic and addiction medications in patients with co-occurring mental and substance use disorders.</td>
<td>MK, SBP</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
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</table>

**EDUCATIONAL OBJECTIVES:**

<table>
<thead>
<tr>
<th>By the completion of the rotation, each fellow will have:</th>
<th>Competencies Addressed</th>
<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved ability to perform a psychiatric diagnostic interview in complex dually diagnosed patients.</td>
<td>PBL, MK, PC, PROF, ICS</td>
<td>DM, CS</td>
<td>AR</td>
<td>FB, DO</td>
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Detox, Pharmacology, Psychosocial Treatment Outpatient Program (ASAP Detox, ASAP Clinic)

The mission of the Addictions and Substance Abuse Programs (ASAP) is to provide comprehensive programs that promote health and prevent substance abuse-related diseases and disabilities. It is our commitment to offer efficient and effective access to necessary treatment and ancillary patient support systems in a cost effective and accountable manner, resulting in improved client functioning, higher client satisfaction, and better client outcomes for all admitted clients. ASAP specializes in providing diverse proven outpatient substance abuse and mental health treatment, including specialized services for women. ASAP provides services to adults and young adults with a primary substance abuse diagnosis and/or individuals who have a substance abuse disorder along with other mental health issues. The ASAP clinic serves approximately 3,000 patients per year; 800 patients are currently in treatment. ASAP has an Opioid Treatment Program that serves over 400 patients on methadone or buprenorphine. Buprenorphine is provided through the Opioid Treatment Program and Office-Based protocols. We have a medical unit that provides assessments for all patients who start methadone, buprenorphine and who may need ambulatory detoxification from drugs of abuse. ASAP has over 13 counselors and one case manager, who provide services to our patients through individual and group counseling sessions. Our clinical psychologist provides supervision to the counseling staff. In addition we have over six nurses who assist in the medical and dispensing clinic. In July of 2010 ASAP began a Primary Care Clinic that provides medical care for our substance abuse patients. At this time we have over 150 patients enrolled.

This six-month outpatient rotation is designed to train fellows in the management of patients with substance use disorders and co-morbid psychiatric disorders. In the Medical Unit, fellows will learn to identify and manage patients exhibiting signs/symptoms of substance withdrawal as well as how to manage substance cravings and relapse risk with newer pharmacologic agents. Fellows will work with counseling staff, and may attend therapy groups run by counselors that help patients learn how to achieve and maintain abstinence. Fellows will
perform psychiatric evaluations of patients dually diagnosed with substance plus co-occurring psychiatric disorders. Attending physicians include: Patrick Abbott, MD, Snehal Bhatt, MD and Julie Bohan, MD.

**PC** – Patient Care  
**PBL** – Practice Based Learning & Improvement  
**ICS** – Interpersonal & Communication Skills  
**MK** – Medical Knowledge  
**PROF** – Professionalism  
**SBP** – Systems-Based Practice  
**AR** – Assigned Reading

**CC** – Case Conference  
**CS** – Clinical Supervision  
**FB** – Feedback  
**DM** – Demonstration  
**DO** – Direct Observation  
**LC** – Lecture  
**MT** – Multidisciplinary Team Case Staffing

**EDUCATIONAL GOALS:**

<table>
<thead>
<tr>
<th>Fellows Will:</th>
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<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Know and become proficient in gathering the components of a thorough substance abuse history</td>
<td>MK, PC, ICS, PBL, PROF</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>2. Become knowledgeable about the signs/symptoms of intoxication and be able to readily identify signs/symptoms of withdrawal of various drugs of abuse including alcohol</td>
<td>MK, PC, PBL</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>3. Become proficient in the evaluation and treatment of patients withdrawing from various drugs of abuse/alcohol</td>
<td>MK, PC, PBL, ICS, PROF</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>4. Develop an understanding of the impact that psychiatric and substance abuse disorders have on one another</td>
<td>PC, MK</td>
<td>CS, DM</td>
<td>MT, AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>5. Develop an understanding of the roles that medications, therapy, and community support have in treatment of substance abuse disorders.</td>
<td>PC, MK, SBP</td>
<td>CS, DM</td>
<td>AR, MT</td>
<td>DO, FB</td>
</tr>
</tbody>
</table>

**EDUCATIONAL OBJECTIVES:**

<table>
<thead>
<tr>
<th>By the completion of the rotation, each fellow will have:</th>
<th>Competencies Addressed</th>
<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Treated outpatients with substance abuse disorders involving the most common drugs of abuse</td>
<td>PC, MK, PBL, ICS, PROF</td>
<td>CS, DM, MT</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>2. Evaluated and initiated treatment for outpatients with dual diagnoses</td>
<td>PC, MK, PBL, ICS, PROF</td>
<td>CS, DM, MT</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>3. Evaluated pregnant substance abusing women with psychiatric disorders</td>
<td>PC, MK, PBL, ICS, PROF</td>
<td>CS, DM, MT</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>4. Completed 8-hour buprenorphine training and provided buprenorphine/methadone induction and maintenance treatment.</td>
<td>PBL, MK</td>
<td>DM, LC</td>
<td>AR</td>
<td>FB</td>
</tr>
<tr>
<td>5. Attended 12-step meeting and/or other self-help</td>
<td>PBL, SBP,</td>
<td>n/a</td>
<td>AR</td>
<td>FB</td>
</tr>
</tbody>
</table>
### Dual Diagnosis Outpatient Clinic (DDx)

Fellows will each spend one half day throughout the year (12 months) in the Dual Diagnosis Clinic at ASAP. In this clinic fellows will supervise residents, medical students, Physician’s Assistant students and nursing staff in their care of patients with concurrent Severe Disabling Mental Illnesses and Substance Use Disorders. This clinic has approximately 100 active patients, 3 attending physicians, 2 addiction fellows, 10 resident physicians, 1 psychologist, 2 nurses and one midlevel provider. The fellows supervise both pharmacological and psychological interventions by the students, nurses and residents.

The clinic has a team approach to clinical care. As such the half day clinic starts out with a treatment team meeting which lasts 1/2 hour. Fellows will give input into treatment planning and decision making regarding acute clinical issues. The treatment team meeting is followed by 1/2 didactic session for the residents and students. Either an attending, a fellow, or a visiting lecturer will run these sessions. The next 3 hours are spent supervising treatment of clinic patients. Fellows will see both new patient assessment and follow up visits with the residents and students. Fellows will function as an autonomous supervisor but may run cases by the attendings as needed.

<table>
<thead>
<tr>
<th>PC – Patient Care</th>
<th>CC – Case Conference</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBL – Practice Based Learning &amp; Improvement</td>
<td>CS – Clinical Supervision</td>
</tr>
<tr>
<td>ICS – Interpersonal &amp; Communication Skills</td>
<td>FB – Feedback</td>
</tr>
<tr>
<td>MK – Medical Knowledge</td>
<td>DM – Demonstration</td>
</tr>
<tr>
<td>PROF – Professionalism</td>
<td>DO – Direct Observation</td>
</tr>
<tr>
<td>SBP – Systems-Based Practice</td>
<td>LC – Lecture</td>
</tr>
<tr>
<td>AR – Assigned Reading</td>
<td>MT – Multidisciplinary Team Case</td>
</tr>
<tr>
<td>Staffing</td>
<td></td>
</tr>
</tbody>
</table>

### EDUCATIONAL GOALS:

<table>
<thead>
<tr>
<th>groups</th>
<th>ICS, PROF</th>
<th>MT</th>
<th>AR</th>
<th>FB, DO</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Performed a literature review of a topic in addiction medicine and participate routinely in a journal club</td>
<td>MK, SBP</td>
<td>MT</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>7. Participated in treatment team and methadone dose change meetings</td>
<td>SBP, ICS, PROF</td>
<td>CS, DM</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>8. Participated in ASAP’s Quality Assurance Meeting and complete a QA project. Participate in death reviews.</td>
<td>SBP</td>
<td>CS</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>9. Observe and participate in group therapy and presented a topic during one group session</td>
<td>MK, ICS, PC, PBL, PROF</td>
<td>CS, DM</td>
<td>AR</td>
<td>FB</td>
</tr>
<tr>
<td>Fellows Will:</td>
<td>Competencies Addressed</td>
<td>Clinical Teaching Methods</td>
<td>Didactic Experience</td>
<td>How Assessed</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>---------------------------</td>
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<td>--------------</td>
</tr>
<tr>
<td>Become proficient in the diagnosis and treatment of patients with co-existing serious and disabling mental illness and substance use disorders.</td>
<td>MK, PC</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Become competent in the supervision of PGY 3 residents treating patients with co-existing serious and disabling mental illness and substance use disorders.</td>
<td>MK, PROF, ICS, SBP, PBL</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Give at least 6 brief lectures to PGY 3 residents and medical students regarding the treatment of patients with co-existing serious and disabling mental illness and substance use disorders.</td>
<td>MK, PBL, ICS, SBP</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Participate for 6 months in weekly journal club regarding the epidemiology, prognosis and treatment of patients with co-existing serious and disabling mental illness and substance use disorders.</td>
<td>MK, ICS PROF</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
</tbody>
</table>

**EDUCATIONAL OBJECTIVES:**

<table>
<thead>
<tr>
<th>By the completion of the rotation, each fellow will have:</th>
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<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ability to apply motivational interviewing techniques in an individual setting</td>
<td>PBL, MK, SBP, PROF, ICS</td>
<td>DM, CS</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>The ability to assume the role of addiction psychiatric expert for individuals with dual diagnoses</td>
<td>PBL, SBP, ICS, PROF, MK</td>
<td>MT, CS, DM, MT</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>The ability to assume the role as educator for psychiatry residents and medical students</td>
<td>PBL, ICS, PROF, MK</td>
<td>CS, DM, MT</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
</tbody>
</table>

**Rural Psychiatry Outreach Program (Telehealth)**

**Rotation Description:**

This 12 month rotation introduces the fellows to the use of tele-and videoconferencing to serve the rural populations of New Mexico. Fellows work closely with the attending physician one half day per week to see patients within and without the Indian Health Services (HIS) system via telehealth.

This rotation provides a unique opportunity for residents to experience issues related to working in rural areas, as well as the complex system arrangements required for proving rural and frontier child/adolescent psychiatric care. Becoming familiar with each community and its local resources, including primary care providers, available mental health services, and school personnel is also prioritized. In addition, the rotation offers the opportunity for some residents to become familiar with new communicative technologies such as videophones and telepsychiatry.
Goal:
The resident will become competent in the provision of child/adolescent psychiatric services in rural and community settings.

**PC** – Patient Care
**PBL** – Practice Based Learning & Improvement
**ICS** – Interpersonal & Communication Skills
**MK** – Medical Knowledge
**PROF** – Professionalism
**SBP** – Systems-Based Practice
**AR** – Assigned Reading

Team Case Staffing

**EDUCATION GOALS:**

<table>
<thead>
<tr>
<th>Fellows Will:</th>
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<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance knowledge of cultural, systems and mental health issues commonly encountered in rural &amp; community addiction psychiatry</td>
<td>MK</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Enhance knowledge of the broader systems issues that enhance or impede the provision of rural and community behavioral health services</td>
<td>MK, PROF, ICS, SBP, PBL</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Enhance knowledge of the unique aspects of rural practice, and adaptations helpful to success;</td>
<td>MK, PBL, SBP</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Enhance knowledge of New Mexico’s public mental health and unique rural/community needs;</td>
<td>MK, SBP</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Enhance knowledge of the clinical, medico-legal, and systems issues in providing outreach services, and strategies to ameliorate them;</td>
<td>MK, SBP, PBL</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Enhance knowledge of the capabilities and limitations of newer communicative technologies such as email, telemedicine, and videophones.</td>
<td>MK, PROF, ICS, SBP, PBL</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
</tbody>
</table>

**EDUCATIONAL OBJECTIVES:**
### By the completion of the rotation, each fellow will have:

<table>
<thead>
<tr>
<th>Competencies Addressed</th>
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<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ability to coordinate rural and community outreach responsibilities with other responsibilities</td>
<td>PBL, MK, PC, PROF, ICS</td>
<td>DM, CS</td>
<td>AR</td>
</tr>
<tr>
<td>The ability to safely and effectively provide direct psychiatric care to patients in a rural/community setting</td>
<td>PBL, SBP, ICS, PROF, MK</td>
<td>CS, DM,</td>
<td>AR</td>
</tr>
<tr>
<td>The ability to develop and preserve a mutually-respectful working relationship with local caregivers and agencies</td>
<td>PBL, ICS, PROF, MK, PC, SBP</td>
<td>CS, DM, MT</td>
<td>AR</td>
</tr>
<tr>
<td>The ability to successfully assume the role of addiction psychiatric expert</td>
<td>PBL, ICS, PROF, MK, PC, SBP</td>
<td>CS, DM, MT</td>
<td>AR</td>
</tr>
<tr>
<td>The ability to maintain patient safety and clinical efficacy in a low-resource setting, including safe and effective clinical innovation and adaptability</td>
<td>MK, PC, SBP</td>
<td>CS, DM,</td>
<td>AR</td>
</tr>
<tr>
<td>The ability to use newer communicative technologies such as e-mail, videophone, and telemedicine</td>
<td>PBL, ICS, PROF, MK, PC, SBP</td>
<td>CS, DM, MT</td>
<td>AR</td>
</tr>
<tr>
<td>Appreciation of the unique challenges faced by rural health care providers and communities</td>
<td>PBL, ICS, PROF, MK, PC, SBP</td>
<td>CS, DM, MT</td>
<td>AR</td>
</tr>
<tr>
<td>Appreciation of the creativity and resourcefulness of rural health care providers and communities;</td>
<td>PBL, ICS, PROF, MK, PC, SBP</td>
<td>CS, DM</td>
<td>AR</td>
</tr>
<tr>
<td>Appreciation of the unique rewards provided by the practice of rural/community psychiatry</td>
<td>PBL, ICS, PROF, MK, PC, SBP</td>
<td>DM</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### Consultation/Liaison Service (VA C/L)

Rotation Description:

This is a required rotation in the Addiction Psychiatry Fellowship and consists of 2 half days for 6 months on the medical and surgical wards of the New Mexico Veterans Affairs Health Care System (NMVAHCS). The NMVAHCS is a level 1 tertiary referral VA serving veteran from West Texas, Eastern Arizona, Southern Colorado and all of New Mexico. The hospital has a total of 217 beds including a 27-bed spinal cord injury unit. It is estimated that up to 7% of veterans meet criteria for a substance use disorder and up to 20% of these may be receiving treatment at any one time.
Addiction fellows on the consultation service see approximately 2 new consults in an afternoon and are responsible for reviewing the history, interviewing the patient on the hospital ward, seeing and discussing the case with the attending physician and developing a comprehensive treatment plan that addresses the medical, psychiatric and substance use disorders and needs of the patient. The fellow is also directly involved with consulting with the team and educating trainees involved in the care of the patient. Fellows provide longitudinal care for patients remaining in the hospital for an extended period and also participate in arranging a suitable outpatient treatment program.

The most common diagnoses fellows manage are delirium tremens and other less severe forms of alcohol and opioid withdrawal, depression in the context of substance use related to its medical complications or as a primary disorder, and assessment of decisional capacity in patients with substance use disorders and psychosocial consequences of their addiction. Fellows also learn to manage chronic pain co-occurring with substance abuse.

Each fellow is provided with a CD containing core CL articles to assist them in the psychosomatic medicine dimensions of the case and the attending provides extensive supervision of the fellow during their rotation discussing all aspects of cases.

The resident will acquire increased skill in the assessment and management of common substance use disorders as the present and interact with medical and other psychiatric conditions at the interface between medicine-surgery and psychiatry.

**EDUCATIONAL GOALS:**

<table>
<thead>
<tr>
<th>Fellows Will:</th>
<th>Competencies Addressed</th>
<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase knowledge of common substance use disorders in the medical and surgical setting and their interaction with other psychiatric disorders.</td>
<td>MK, PC,</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Increase knowledge of the medical and surgical complications of substance use disorders particularly states of intoxication and withdrawal and their characteristic presentations and/or signs and symptoms</td>
<td>MK, PC,</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Increase knowledge of medical workups for substance use disorders in the hospitalized patients including pertinent lab tests, neuroimaging, physical and neurological examination, cognitive testing, history taking and chart review</td>
<td>PC, MK</td>
<td>CS, DM</td>
<td>MT, AR</td>
<td>DO, FB</td>
</tr>
</tbody>
</table>
Increase understanding of complicated and severe withdrawal from substances in patients with co-occurring surgical, medical and psychiatric disorders

Increase knowledge of the use of psychotropic medications in patients with co-occurring medical and substance use disorders.

Acquire increased skill in the assessment and management of common substance use disorders as the present and interact with medical and other psychiatric conditions at the interface between medicine-surgery and psychiatry.

**EDUCATIONAL OBJECTIVES:**

<table>
<thead>
<tr>
<th>By the completion of the rotation, each fellow will have:</th>
<th>Competencies Addressed</th>
<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved ability to perform an neuropsychiatric examination of a patient who is delirious, divisionally incapable, intoxicated, threatening, withdrawing or physically ill</td>
<td>PC, MK, CS, DM, MT</td>
<td>AR</td>
<td>FB, DO</td>
<td></td>
</tr>
<tr>
<td>Improved ability to utilize brief interventions and motivational interviewing to intervene in patients with end-stage and chronic substance use and other co-occurring disorders.</td>
<td>PC, MK, PBL, ICS, PROF</td>
<td>AR</td>
<td>FB, DO</td>
<td></td>
</tr>
<tr>
<td>Improved ability to develop a differential diagnosis and treatment plan to address substance use disorders complicated by and complicating medical and surgical problems (either by treatment, by consultation, or by referral);</td>
<td>PC, MK, PBL, ICS, PROF</td>
<td>AR</td>
<td>FB, DO</td>
<td></td>
</tr>
<tr>
<td>Improved ability to obtain necessary medical information from electronic medical record and with appropriate consent collateral sources.</td>
<td>PBL, MK, SBP, PROF</td>
<td>DM, LC</td>
<td>AR</td>
<td>FB</td>
</tr>
<tr>
<td>Improved ability to work collaboratively with health care professionals and liaison with medical and surgical teams and</td>
<td>PBL, SBP, ICS, PROF</td>
<td>n/a</td>
<td>AR</td>
<td>FB</td>
</tr>
<tr>
<td>Enhanced recognition of the morbidity and mortality of advanced substance use disorders</td>
<td>MK, MT</td>
<td>AR</td>
<td>FB, DO</td>
<td></td>
</tr>
<tr>
<td>Enhanced respect for the challenges non-specialist providers face in attempting to diagnose and manage substance use disorders in a hospital setting</td>
<td>SBP, ICS, PROF, PBL</td>
<td>CS, DM</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>Enhanced appreciation of the fellow’s role as an educator and liaison for other health care professionals and trainees</td>
<td>PBL, SBP, PROF, ICS</td>
<td>CS</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>Enhanced awareness of the ethical dimensions of treating patients with serious medical, psychiatric and substance use disorders</td>
<td>MK, ICS, PC, PBL, PROF</td>
<td>CS, DM</td>
<td>AR</td>
<td>FB</td>
</tr>
</tbody>
</table>

**Research Rotation (Center for Alcohol, Substance Abuse, and Addictions CASAA)**

**Rotation Description**
Addiction Psychiatry fellows will complete a year-long (12 month) research experience in which they will participate in an ongoing addictions research project, initiated either by a UNM investigator or by the fellow. Depending on the characteristics of the study, its duration and its stage of development, fellows will participate in protocol development, implementation, data collection, analysis, and/or publication.

| PC – Patient Care | CC – Case Conference |
| PBL – Practice Based Learning & Improvement | CS – Clinical Supervision |
| ICS – Interpersonal & 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 |

**E D U C A T I O N  G O A L S  A N D  O B J E C T I V E S :**

<table>
<thead>
<tr>
<th>Fellows Will:</th>
<th>Competencies Addressed</th>
<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase their understanding of the conduct of addictions research through direct participation in ongoing research.</td>
<td>MK, PBL</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
</tbody>
</table>
Submit for publication at least one scholarly manuscript, which may be related to the research in which they are participating, or, if this is not feasible because of the developmental stage of the study, may be based on literature review, secondary analysis, or case report.

<table>
<thead>
<tr>
<th>Competencies Addressed</th>
<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>MK, PROF, ICS, SBP, PBL</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
</tbody>
</table>

Truman Street Clinic Rotation

Rotation Description
The University of New Mexico Health Sciences Center (UNMHSC) Truman Street Health Clinic is a clinic providing HIV-specific primary health care for persons living with HIV. This 6 month outpatient rotation (one-half day a week) is designed to train fellows in the management of patients with substance use disorders, co-morbid psychiatric disorders in HIV patients. Fellows will work with the clinic’s medical staff, social worker and counseling staff and case managers from New Mexico’s AIDS Services (NMAS). Fellows will perform evaluations of patients with substance plus co-occurring psychiatric disorders and HIV. Attending physicians include: Patrick Abbott, MD, Snehal Bhatt, MD and Bruce Williams, MD.

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

EDUCATIONAL GOALS:

Fellows Will:

1. Know and become proficient in gathering the components of a thorough substance abuse history in the context of HIV
   - Competencies Addressed: MK, PC, ICS, PBL, PROF
   - Clinical Teaching Methods: CS, DM
   - Didactic Experience: AR
   - How Assessed: DO, FB

2. Develop an understanding of the impact that psychiatric and substance abuse disorders have on one another and on patients with HIV
   - Competencies Addressed: PC, MK
   - Clinical Teaching Methods: CS, DM
   - Didactic Experience: MT, AR
   - How Assessed: DO, FB

3. Become aware of drug interactions between HIV
   - Competencies Addressed: PC, PBL, MK
   - Clinical Teaching Methods: CS, FB, DM
   - Didactic Experience: AR, MT
   - How Assessed: DO, FB
and psychiatric medications.

4. Develop an understanding of the roles that medications, therapy, and community support have in treatment of substance abuse disorders.

<table>
<thead>
<tr>
<th>Educational Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>By the completion of the rotation, each resident will have:</strong></td>
</tr>
<tr>
<td>1. Treated outpatients with substance abuse disorders involving the most common drugs of abuse</td>
</tr>
<tr>
<td>2. Evaluated and initiated treatment for outpatients with triple diagnoses (HIV)</td>
</tr>
<tr>
<td>3. Attended 12-step meeting and/or other self-help groups</td>
</tr>
<tr>
<td>4. Participate in Behavioral Health Team meetings</td>
</tr>
</tbody>
</table>

**Children’s Psychiatric Center (CPC) Consult & Group**

**Rotation Description:**
This rotation is for six months, one half day per week, and gives the fellow the opportunity to work with adolescents with substance abuse issues. Fellows co-facilitate a motivational-interviewing/Community Reinforcement Treatment based substance abuse group which is weekly and lasts an hour for residential patients and acute inpatient individuals with substance abuse and dependence diagnoses at Children’s Psychiatric Center (CPC). In addition, fellows see patients one-on-one for individual therapy sessions who are either in residential or acute inpatient treatment at CPC. Some of the patients are adjudicated. For group experiences, fellows are supervised by an addiction psychiatry faculty or by child and adolescent psychiatry faculty. For individual therapy, fellows are supervised by a child and adolescent psychiatrist.

**Goal:**
The fellow will become competent in the provision of services to adolescent patients with substance abuse and dependence diagnoses.

<table>
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<tbody>
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<tr>
<td>PROF – Professionalism</td>
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</table>
EDUCATIONAL GOALS:

<table>
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<tr>
<th>Fellows Will:</th>
<th>Competencies Addressed</th>
<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance knowledge of evidence based practices for treatment of adolescent patients with substance abuse issues</td>
<td>MK, PC</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Enhance knowledge of epidemiology of substance abuse issues in adolescent patients</td>
<td>MK, PC</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Enhance knowledge of adverse effects of substance use in adolescents, both in the short term, and in the long term</td>
<td>PC, MK</td>
<td>CS, DM</td>
<td>MT, AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Enhance knowledge of normative behaviors in adolescents (compared to diagnosing substance abuse and dependence)</td>
<td>PC, MK,</td>
<td>CS, DM</td>
<td>AR, MT</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Enhance knowledge of resources to get information about adolescent substance abuse</td>
<td>MK, PC, SBP</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
</tr>
<tr>
<td>Enhance knowledge of referral sites in New Mexico for adolescents with substance abuse and dependence</td>
<td>MK, PC, SBP</td>
<td>CS, DM</td>
<td>AR</td>
<td>DO, FB</td>
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EDUCATIONAL OBJECTIVES:

<table>
<thead>
<tr>
<th>By the completion of the rotation, each fellow will have:</th>
<th>Competencies Addressed</th>
<th>Clinical Teaching Methods</th>
<th>Didactic Experience</th>
<th>How Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ability to work with adolescents in a group setting</td>
<td>PC, MK</td>
<td>CS, DM,</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>The ability to work with adolescents in an individual setting</td>
<td>PC, MK, PBL, ICS, PROF</td>
<td>CS, DM,</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>The ability to apply motivational interviewing techniques in a group setting</td>
<td>PC, MK, PBL, ICS, PROF</td>
<td>CS, DM,</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>The ability to apply motivational interviewing techniques in an individual setting</td>
<td>PBL, MK, SBP, PROF, ICS</td>
<td>DM, CS</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>The ability to assume the role of addiction psychiatric expert for adolescents</td>
<td>PBL, SBP, ICS, PROF</td>
<td>MT, CS, DM</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
<tr>
<td>The increased comfort level and enjoyment of working with</td>
<td>PBL</td>
<td>CS, DM</td>
<td>AR</td>
<td>FB, DO</td>
</tr>
</tbody>
</table>
SCHEDULED SEMINARS, CONFERENCES, and COMMITTEE WORK

1. Seminar in Basics of Addictive Disorders
   a. Required for Addiction Residents
   b. C. Wilcox, M.D., M. Bogenschutz, M.D., and other departmental faculty depending on specialty.
   c. This seminar covers topics in addictions psychiatry using extensive readings from the ASAM, AAAP, and the Lowinson’s Substance Abuse: A Comprehensive Textbook. Topics covered: neurobiology, epidemiology, genetics, cross-cultural aspects of addiction, and assessment.
   d. Addiction Residents only
   e. 1 hour weekly for 12 weeks

2. Specific Drugs of Abuse
   a. Required for Addiction Residents
   b. C. Wilcox, M.D., D. Duigg, D.O., S. Bhatt, M.D.
   c. This seminar will cover all drugs of abuse, such as, alcohol, stimulants, nicotine, opioids, hallucinogens, benzodiazepines, marijuana and others with readings from major textbooks and journals.
   d. Addiction Residents only
   e. 1 hour weekly for 14 weeks

3. Treatment Modalities
   a. Required for Addiction Residents
   b. C. Wilcox, M.D., A. Forcehimes PhD., P. Abbott, M.D.
   c. This seminar will cover all evidence-based psychosocial and pharmacological modalities with reading from major textbooks and journals.
   d. Addiction Residents only
   e. 1 hour weekly for 12 weeks

4. Special Topics in Addictions
   a. Required for Addiction Residents
   b. C. Wilcox, M.D., P. Arenella, M.D., P. Abbott, M.D. and other faculty depending on specialty
   c. This will cover special populations such as mentally ill substance abusers, perinatal substance abuse, substance abuse in physicians and special issues such as forensic addiction, prevention, neuropsychiatric impairment, cost effectiveness of treatment, administrative, ethical and others.
   d. Addiction Residents only
   e. 1 hour weekly for 12 weeks

5. Addiction Psychiatry Journal Club
a. Required for Addiction Residents
b. C. Wilcox, M.D.
c. Residents present to the group a structured critique of a significant empirical paper from the addiction research literature, including assessment of methodology, conclusions drawn from the data, and clinical and scientific significance.
d. General Psychiatry Residents
e. 1 hour monthly for 12 months. (Meets fourth Friday of each month at ASAP.)

6. Addiction Clinical Case Conference

a. Required for Addiction Residents
c. Reviews the care of a hospitalized patient who is an outpatient of one of the addiction services. An addiction psychiatry faculty member will serve as discussant. The residents caring for the patient will give a formal presentation of the case, and if appropriate, the patient will be interviewed by the faculty member, who will then lead a discussion of the case. Case Conferences will also be done for outpatients that a resident cares for at Dual Diagnosis and ASAP during their team meetings.
d. General Psychiatry Residents
e. 60 minutes, once a month.

7. Psychiatry Grand Rounds

a. Required for Addiction Residents
b. Various faculty of the University of New Mexico and other experts in the field of behavioral health.
c. Various lecture topics in the field of behavioral health.
d. All Psychiatry trainees, Psychology Internship trainees, Psychiatry faculty.
e. 1 ½ hours weekly for 35 weeks.

8. Group psychotherapy supervision

- Required for addiction psychiatry residents with their respective rotation supervisors.
- Weekly supervision of group and individual treatment, including use of motivational interviewing, cognitive-behavioral, and 12-step approaches.

9. Teaching of medical students

- Residents will participate in medical student education by giving a monthly 90 minute talk on addictions to phase II medical students on Neurosciences rotation.

10. ASAP Quality Assurance Committee

- Residents will serve and participate in Quality Assurance activities as members of the ASAP QA committee. All residents will be required to complete a Quality Assurance project and participate in death reviews.

11. Division meetings and Addiction Psychiatry Training and Competency Committee

- Residents will attend monthly Addiction Psychiatry division meetings quarterly and will serve as a member of the Addiction Psychiatry Training and Competency Committee (but will not participate in confidential discussions of resident performance).
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 Addiction 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.
ADDICTION PSYCHIATRY FELLOWS’ GRADUATION REQUIREMENTS

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

POLICY:

Satisfactory completion of all required rotations to include the following: 12 months Dual Disorder, 6 months ASAP, 6 months VA Inpatient and Consultation Service, 6 months Truman Street, 12 months research, 12 months Rural and 6 months CPH (see above for complete description).

Through various evaluation processes, fellows must demonstrate competency in medical knowledge, patient care, systems-based practice, professionalism, interpersonal communication, and practice-based learning.

Seminars: must attend at least 70% of all required seminars.

Record of cases seen by fellows. A variety of patients, diagnoses and treatment modalities must be a part of this record.

UNM PSYCHIATRY ADDICTION 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. Addiction Psychiatry fellows in training are at all times supervised by an assigned attending physician in all settings, e.g. clinical attending, hospital 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 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 addiction psychiatrists 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, hospitals,) there may also be a site medical director, or other site official who should also be consulted as appropriate.
QUALITY IMPROVEMENT AND SAFETY PROJECTS

PURPOSE: All fellows will be integrated and actively participate in interdisciplinary clinical quality improvement and patient safety projects. This will enhance their ability to demonstrate practice-based learning and improvement competencies with the ultimate goal of improving patient care practices.

POLICY:

1) Fellows will systematically analyze practice using quality improvement methods, such as, Plan, Do, Study, Act (PDSA), and implement changes with the goal of practice improvement. These methods may include case-based learning, use of best practices, critical literature review, obtaining appropriate supervision or consultation and record reviews of patient evaluations. The fellows will locate, appraise an assimilate evidence from the scientific literature related to their patients’ health problems.

2) Fellows will attend monthly Quality Assurance meetings during their 6 month rotation at ASAP. They are required to complete and document a quality assurance/safety project during this rotation.

3) Fellows will attend the medical staff meetings for death and peer reviews.

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 Addiction 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 through structure of the training experience 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.

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**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.

4. 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.

5. 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.

6. 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 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 (a. through c. 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:
Fellow with clinical or educational concern

On site faculty

Associate Training Director

Training Director

Residency Training Committee

Chairman

Assoc. Dean for Graduate Medical Education

Ombuds-person
DIDACTIC SEMINARS

PURPOSE: To insure fellows the opportunity to learn in a scholarly fashion the body of knowledge that contemporary addiction 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 Addiction Psychiatry didactic seminars. These include the Addiction 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.

2. The seminar series will be coordinated by faculty of the Addiction 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 Addiction 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.

7. Schedules for the didactic seminars will be provided to the fellows at the start of the fellowship. (See list of topics page 25)
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 to 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).
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 \textit{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 President for Health Sciences, who will convene a three-person ad hoc committee to review the request and advise the Executive Vice President, 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 Addiction 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, Addiction 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 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 Addiction Psychiatry Faculty Group, which is made up of the following members: Director of Fellowship Training, other key Addiction Psychiatry Faculty, Fellow(s) and the Fellowship Coordinator. This committee meets the second Friday of the month from 8:00 AM to 9:00AM at ASAP. 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 addiction 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, ASAP 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.
**DUTY HOURS POLICY**

**DEPARTMENT OF PSYCHIATRY ◆ DIVISION ADDICTION PSYCHIATRY**

**FORMAL POLICY ON DUTY HOURS IN THE ADDICTION PSYCHIATRY FELLOWSHIP PROGRAM**

It is the policy of the Addiction Psychiatry program to follow the duty hours policy set forth by the ACGME and the University of New Mexico GME office. The program amends the formal GME policy to include a specific plan of who to contact in the event that a fellow is nearing a violation in duty hours.

Duty hours are defined by the ACGME as all clinical activities related to the residency program, i.e. patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

The ACGME Duty Hours Requirements, which are minimum duty hour standards for all residency and fellowship programs (unless granted program specific exemptions by the ACGME and by UNM) are as follows: Houseofficers work week which must not exceed eighty (80) hours averaged over a four-week period, inclusive of all in-house call activities. Houseofficers must receive one day off in seven 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 of all clinical, educational, and administrative activities. In-house call is to be no more frequent than every third night averaged over a four-week period. There must be 10-hour period provided between all daily duty periods and after in-house call. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Houseofficers may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care (unless further limited by the relevant program requirements). No new patients may be accepted after 24 hours of continuous hours on duty.

At this time, no UNM residency or fellowship programs have been granted exemption from these minimum standards. Specific RRC duty hour regulations (e.g., Internal Medicine, Emergency Medicine) may be more restrictive than the duty hours standards described above, and those residency programs must have departmental duty hours policy compliant with the standards of their RRC.

Each program shall distribute a copy of the departmental duty hour policy to all Houseofficers physicians and faculty. It is the primary responsibility of the sponsoring program to assure compliance with RRC duty hour regulations regardless of the Houseofficer’s rotation on or off of the service.
Houseofficers shall report duty hours truly, completely, and correctly in accordance with institutional requirements via New Innovations.

The duty hour policy promotes the educational environment, supports the physical and emotional well-being of Houseofficers, and provides for patient safety.

DUTY HOURS PROTOCOL

All University of New Mexico ACGME accredited programs, as well as the dental program, must achieve and maintain compliance with the resident duty hour regulations for their respective RRC. The Office of Graduate Medical Education will regularly monitor resident duty hours for compliance with the institutional duty hour limitations and RRC regulations. The following policy outlines the procedures that will be used by the institution.

1. The Office of GME will collect and maintain a file containing all of the individual program policies concerning resident duty hours.
2. The Office of GME will provide New Innovations as a method for all programs to track resident duty hours, and all programs will be expected to utilize this standard reporting tool. All residents and fellows will be required to input duty hours by Tuesday of each week for all hours worked the previous week (Tuesday to Monday). The GMEC will monitor duty hour compliance with random query of specific rotations and individuals trainees utilizing New Innovations. If violations are noted as a result of the random audit, information will be collected and other audits may be performed of the rotation or a survey may be conducted of the program.
3. The Office of Graduate Medical Education periodically survey any program at random to ensure they are in compliance with RRC regulations on duty hours and to monitor for fatigue, as well as the residents satisfaction with their respective program.
4. The Office of GME will request action plans from individual programs concerning individual rotations or residents that are not in compliance with RRC and institution regulations. The Office of GME will encourage the individual departments to involve residents in the preparation of these plans. The Office of GME will follow up on concerning progress on these action plans until it appears to be appropriately resolved.
5. Any individual (Housestaff or faculty) aware of a violation of the policy mandating that Houseofficer’s work no more than 24 continuous hours with a 6 hour period to transition care (i.e. 30 hours of continuous service) must report the instance to their Program Director immediately. The program must prepare a response plan and provide the Office of GME with an action plan within 72 hours of the report of the violation.
6. The institution will maintain a confidential web based reporting tool for residents to report duty hour violations. Upon notice of such reporting through a) the institutional web site, b) a report through an RRC resident survey, or c) a report to the institution from the ACGME; The Office of GME will conduct focus group session with the residents participating in various rotation to assess not only compliance with the resident duty hour regulations but also to assess educational aspects, resident fatigue/stress and quality of life issues.
7. The internal review committee will include questions concerning resident duty hours during the reviews of the programs. The institutional annual resident satisfaction survey will solicit information on duty hour compliance. These reports will be included in the summaries submitted to the GMEC. The Office of GME under the direction of the DIO will submit a report to the Dean of the
School of Medicine and the medical staff governing body of each major participating institution annually on resident duty hour compliance.

REPORTING DUTY HOUR VIOLATIONS

All Addiction Psychiatry faculty are to monitor duty hours to ensure that fellows do not violate the duty hours policy. Fellows in danger of a duty hours violation should contact their supervisor, the Program Director, Patrick Abbott, MD, or the Coordinator, Andrea Chapman as soon as it is apparent they may violate the policy so that the program may prevent the violation.

Houseofficers may report duty hour violations on any rotation at the following reporting site: http://hsc.unm.edu/som/GME/hours.cfm. This site provides complete confidentiality of the Houseofficer who is making the report.

Departmental Contact Information for Reporting Violations:

Patrick Abbott, MD, Office 925-2401 email: pabbott@salud.unm.edu

Andrea Chapman: Office: 272-5002 email: ADChapman@salud.unm.edu
CORE COMPETENCIES

Addiction Psychiatry Patient Care Core Competencies

Addiction psychiatrists shall communicate effectively and demonstrate caring and respectful behaviors when interacting with substance use-disordered patients and their families.

Addiction psychiatrists shall gather essential and accurate information through interviews with their patients, family members, caregivers and other health professionals with attention to:

1) Relevant psychiatric and substance use history
2) Medical history, physical exam, and laboratory and diagnostic tests.
3) Family history
4) Social and developmental history
5) Community and environmental assessment (e.g., community supports, housing, safety, etc.)
6) Functional assessment
7) Mental status examination

Addiction psychiatrists shall develop a multiaxial diagnosis and formulation of biopsychosocial information.

Addiction psychiatrists shall develop an evaluation plan which may include selection and use of ancillary investigations, corroborative history or information, laboratory tests, radiology/imaging, electrophysiologic, polysomnographic and neuropsychologic tests.

Addiction psychiatrists shall make informed decisions about therapeutic interventions based on patient information and preferences, up-to-date scientific evidence in the field, and clinical judgment.

Addiction psychiatrists shall develop and carry out a comprehensive treatment plan addressing biological, psychological and sociocultural domains, including:

1) Consultative and primary care (short-term as well as longitudinal management) for addiction patients in both inpatient and outpatient settings
2) Organization and integration of input and recommendations from the multidisciplinary mental health team as well as integrating recommendations and input from primary care physicians, consulting medical specialists and representatives of other allied disciplines
3) Use of information technology to support patient care decisions and patient education
4) Communicating treatment plans to and educating addiction psychiatric patients, their families and caregivers
5) Initiation and flexible guidance of treatment, with the need for ongoing monitoring of changes in mental and physical health status and medical regimens
6) Recognition and management of psychiatric co-morbid disorders,
7) Knowledgeability concerning diagnosis and treatment of medical disorders commonly seen in addiction patients (e.g., viral hepatitis, HIV, alcoholic liver disease, etc.)

Regarding pharmacotherapy, addiction psychiatrists shall:

1) Recognize drug interactions, non-compliance, psychiatric manifestations of iatrogenic influences, such as overmedication and misuse of medications as well as strategies to correct these issues.
2) Recognize indications for, side effects of, and therapeutic limitations of pharmacotherapies for addictive disorders, and special issues in the use of psychiatric medications in patients with addictions.

Regarding psychotherapy, addiction psychiatrists shall:

1) Identify patients and presenting problems likely to be appropriate for the various psychotherapies (e.g., MET, CBT, 12-step facilitation, contingency management).
2) Develop a working formulation of the relevant issues for the specific recommended therapy.
3) Maintain awareness of appropriate modifications in techniques and goals in applying these psychotherapies and behavioral strategies to the mentally ill (with individual, group, and family focuses).
4) Understand the process, benefits, and limitations of 12-step and other mutual help groups, and facilitate beneficial patient involvement in these groups.

Regarding management of ethical and legal issues pertinent to addiction psychiatry, addiction psychiatrists shall obey the law and adhere to professional standards of ethical conduct with respect to:

1) Informed consent
2) Confidentiality
3) Involuntary treatment
4) Duty to warn and duty to protect
5) Reporting suspected abuse or neglect of children or vulnerable adults.

Addiction psychiatrists shall work with health care professionals, including those from other disciplines, to provide patient-focused care including:

1) Formal and informal administrative leadership of the addiction mental health care team which may include representatives from related clinical disciplines, such as psychology, social work, psychiatric nursing, activity or occupational therapy, physical therapy, pharmacology, counseling and nutrition.
2) Liaison with individuals representing disciplines within medicine, such as family practice and internal medicine, neurology, and physical medicine and rehabilitation.

Addiction Psychiatry Medical Knowledge Core Competencies

Addiction psychiatrists shall demonstrate knowledge about established and evolving biomedical, clinical and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to the care of addiction psychiatric patients and their families. Addiction psychiatrists are expected to:

1) Demonstrate an investigatory and analytic thinking approach to clinical situations; and
2) Know and apply the basic and clinically supportive sciences, which are appropriate to their discipline.

Addiction psychiatrists shall develop and apply specific knowledge for education in addiction psychiatry, including:

3) Phenomenology of addiction
4) Epidemiology of addiction
5) Neuroscience of addiction
6) Pharmacology of specific substances
   a. Alcohol and CNS Depressants
   b. Stimulants
c. Opioids and Analgesics
d. Cannabinoids
e. Inhalants
f. Hallucinogens
g. Club drugs and miscellaneous substances of abuse
h. Problematic Use of Over-the-Counter Drugs and caffeine
i. Nicotine

7) Issues Related to Multi-Drug Abuse and Dependence
8) Co-Occurring Disorders: Overview of Symptomatology, Epidemiology, Diagnostic Issues, and Treatment Modalities
9) Psychosocial Modalities for Substance Abuse Disorders
10) Integration of Pharmacologic Modalities and Psychotherapies
11) Medical Sequelae of Substance Abuse and Dependence
12) Prevalence and Nature of Substance Abuse and Dependence in New Mexico
13) Sociocultural Aspects of Substance Abuse and Dependence
14) Different Ideological Views on the Issue of Substance Abuse and Dependence
15) Ethical and Medicolegal Issues in the Field of Substance Abuse
16) Clinical and Cost Effectiveness in the Practice of Addiction Medicine

**Addiction Psychiatry Interpersonal and Communication Skills Competencies**

Addiction psychiatrists shall be able to demonstrate interpersonal and communication skills that result in effective and empathic information exchange and teaming with addiction psychiatric patients, families, colleagues, staff and systems. Interpersonal skills require an understanding of the addiction psychiatrist’s role as a consultant to patients and their contextual system. Development of interpersonal skills is enhanced by the acquisition of basic information about interpersonal communication.

Addiction psychiatrists shall create and sustain a therapeutic and ethically sound relationship with addiction psychiatric patients and their families from a spectrum of available ethnic, racial, cultural, gender, socioeconomic and educational backgrounds.

Addiction psychiatrists shall understand the impact of transference and countertransference impact on treatment of addiction psychiatric patients.

Addiction psychiatrists shall use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning and written skills as appropriate with addiction psychiatric patients and their families.

Addiction psychiatrists shall communicate effectively and work collaboratively with others as a member or leader of a addiction psychiatric mental health care team which may include representatives from related clinical disciplines such as psychology, social work, nursing, occupational therapy, activity and physical therapy, pharmacy and nutrition.

Addiction psychiatrists shall communicate effectively and work collaboratively with other health care teams, if available, such as family medicine, internal medicine (including their addiction subspecialties), neurology and physical medicine and rehabilitation. Addiction psychiatrists shall facilitate the learning of students and other health care professionals such as other addiction psychiatrists, medical students, nurses and allied health professionals.
Addiction Psychiatry Practice-Based Learning and Improvement Competencies

Addiction psychiatrists shall be able to investigate and evaluate their patient care, appraise and assimilate scientific evidence and improve their patient care practices.

Addiction psychiatrists shall be able to recognize limitations in his/her knowledge base and clinical skills and understand and address the need for lifelong learning.

Addiction psychiatrists shall be able to demonstrate an ability to continually expand his/her knowledge and skills and assesses his/her practice to ensure highly competent evaluation and treatment of psychiatric disorders in addiction patients and their families.

Addiction psychiatrists shall demonstrate appropriate skills for obtaining up-to-date information from the scientific and practice literature and other sources to assist in the quality care of patients. Addiction psychiatrists are expected to:

1. Locate, critically appraise and assimilate evidence from scientific studies and literature reviews related to their addiction patients’ mental health problems to determine how quality of care can be improved in relation to ones practice
2. Apply knowledge of research study designs and statistical methods related to addiction psychiatry to the appraisal of such clinical studies and other information on diagnostic and therapeutic effectiveness
3. Use medical libraries and information technology, including internet-based searches and literature and drug databases, e.g., Medline, to manage information, access on-line medical information and support their own education
4. Facilitate the learning of students and other health care professionals such as other addiction psychiatrists, medical students, nurses and allied health professionals
5. Analyze practice experience and perform practice-based improvement activities using a systematic methodology which may include case-based learning, use of best practices, critical literature review, obtaining appropriate supervision or consultation, record review or patient evaluations
6. Obtain and use information about their own population of addiction psychiatric patients and the larger population from which their patients are drawn.

Addiction Psychiatry Professionalism Skills Competencies

Addiction psychiatrists must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse addiction psychiatric patient population.

Addiction psychiatrists shall be expected to demonstrate respect.

Addiction psychiatrists shall demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care.

Addiction psychiatrists shall demonstrate sensitivity and responsiveness to patients’ culture.

Addiction psychiatrists shall demonstrate responsibility for his/her addiction psychiatric patient’s care by responding to patient communications and other health professionals in a timely manner.

Addiction psychiatrists shall demonstrate understanding of and sensitivity to end of life care and issues regarding provision of care.
Addiction psychiatrists shall review their professional conduct and remediate when appropriate.

Addiction psychiatrists shall participate in the review of the professional conduct of their colleagues.

Addiction psychiatrists shall be aware of safety issues, including acknowledging and remediating medical errors, should they occur.

**Addiction Psychiatry Systems-Based Practice Skills Competencies**

Addiction psychiatrists shall be able to treat substance use disordered patients with psychiatric and/or neuropsychiatric problems within the context of multiple, complex intra-organization and extra-organization systems. The resident shall have a working knowledge of the larger context and the diverse systems involved in treating addiction patients and their family members and understand how to use and integrate multiple systems of care as part of a comprehensive system of care, in general and as part of a comprehensive, individualized treatment plan.

Addiction psychiatrists shall be aware of how types of addiction psychiatric practice and delivery systems differ from one another.

Addiction psychiatrists shall demonstrate knowledge of community systems of care and assist patients to access appropriate care and other support services. This requires knowledge of treatment settings in the community.

Addiction psychiatrists shall understand how to partner with health care managers and health care providers to assess, coordinate and improve addiction mental health care and know how these activities can affect system performance. Addiction psychiatrists shall demonstrate knowledge of community systems of care and assist patients to access appropriate care and other support services. Addiction psychiatrists shall demonstrate knowledge of the organization of care in each relevant delivery setting and the ability to integrate the care of patients across such settings.

Addiction psychiatrists shall understand how their addiction psychiatric care and other professional practices affect other health care professionals.

Addiction psychiatrists shall practice cost-effective addiction psychiatric care and resource allocation that does not compromise quality of care with attention to practice guidelines and community.

Addiction psychiatrists shall advocate for quality patient care and assist addiction psychiatric patients in dealing with system complexities such as limitation of resources for health care.

Addiction psychiatrists shall be aware of how types of addiction psychiatric practice and delivery systems differ from one another.
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/paethics.pdf

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The Principles of Medical Ethics 2006 Edition

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.
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.

   g. 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.
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).
 o DON’T START CALL WITH A SLEEP DEFICIT
  • Recovery from sleep loss takes 2 nights of extended sleep to restore baseline alertness.
    o Recovery sleep generally has a higher percentage of deep sleep.
  • Sleep Hygiene isn’t just for patients
    o Have a regular sleep schedule.
    o Follow a regular routine prior to retiring for the night.
    o Engage in some relaxing activity before sleep.
    o Protect your sleep time.
 o 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
 o Exercise helps, but vigorous exercise 3-4 hours before retiring can make it difficult to fall asleep.
 o 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 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).

_________________________  ______________________  ____________
Signature                Print Name                Date
EXHIBITS

ADDITION PSYCHIATRY RESIDENCY TRAINING PROGRAM
EVALUATION OF ROTATION BY FELLOW

Evaluator:  Subject:
Rotation:  
Employer:  

<table>
<thead>
<tr>
<th>Relevance of experience</th>
<th>1 = Poor</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 = Excellent</th>
<th>N/A</th>
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<thead>
<tr>
<th>Quantity of supervision</th>
<th>1 = Poor</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 = Excellent</th>
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<th>Quality of supervision</th>
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<tr>
<th>Atmosphere</th>
<th>1 = Poor</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 = Excellent</th>
<th>N/A</th>
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<thead>
<tr>
<th>Patient Population Suitability</th>
<th>1 = Poor</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 = Excellent</th>
<th>N/A</th>
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<tr>
<th>Quality of staff</th>
<th>1 = Poor</th>
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<th>5 = Excellent</th>
<th>N/A</th>
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<tr>
<th>Working relationship with staff</th>
<th>1 = Poor</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 = Excellent</th>
<th>N/A</th>
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</table>
### Availability of consultants

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<tr>
<th>1 = Poor</th>
<th>2</th>
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<th>4</th>
<th>5 = Excellent</th>
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### Quality of care delivery

<table>
<thead>
<tr>
<th>1 = Poor</th>
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<th>5 = Excellent</th>
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### Workload

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<thead>
<tr>
<th>1 = Poor</th>
<th>2</th>
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<th>5 = Excellent</th>
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### Overall evaluation

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<tr>
<th>1 = Poor</th>
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<th>4</th>
<th>5 = Excellent</th>
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</table>

### Overall Comments:

Remaining Characters: 5000
Please choose the point on the 1-5 scale that best represents your rating of the indicated item.

Knowledge Base-Supervisor refers the resident to relevant publications and resources; references multiple theoretical approaches; guides the resident in mastering the literature

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<th></th>
<th>1 = Poor</th>
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Comments

Remaining Characters: 5000

Organization - Supervisor clearly communicates goals and expectations; is prepared for meetings; is not preoccupied or distracted by other tasks; helps the fellow organize his/her experience and practice

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Comments

Remaining Characters: 5000

Assessment Skills-Supervisor helps the resident plan and conduct clinical assessments; helps shape assessments to the available resources and goals; helps integrate assessments with subsequent diagnosis, formulation, and treatment planning

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Comments

Remaining Characters: 5000

Diagnosis and Case Formulation-Supervisor helps the resident learn and master the DSM-IV, biopsychosocial formulations, psychodynamic formulations, and system formulations

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Comments

Remaining Characters: 5000

Systems-Supervisor increases the resident's ability to assess, understand, and integrate various systems that influence the patient's functioning; helps the resident learn how to address systems issues to enhance patient's outcomes

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Comments

Remaining Characters: 5000

Culture-Supervisor enhances the resident's awareness and appreciation of cultural issues and differences; increases the resident's respect for cultural issues; increases the resident's ability to work comfortably with patients and families of different cultures

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<th>5 = Excellent</th>
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Comments

Remaining Characters: 5000

Treatment Planning-Supervisor helps the resident develop and

Case Management-Supervisor helps the resident in day-to-day
implement treatment plans based on preceding assessment; helps the fellow increase individualization and sophistication of treatment plans; helps shape plans based on existing resources and limitations

management of patient care, direction of the course of treatment, collaboration with other professionals and team members, ability to address systems issues and management practicalities

Professionalism-Supervisor treats the resident as a professional; is available for additional consultation when needed; is appropriately supportive while also fostering independence; respects the resident's judgment and level of development; is flexible and open; maintains appropriate authority and protests patient safety; is enthusiastic about psychiatry; serves as a role model

Integration-Supervisor helps the resident integrate the various elements of high-quality clinical practice, and the various theoretical orientations, into a functioning whole

Environmental Issues-Supervisor increases the resident's ability to consider, evaluate, and integrate environmental issues into patient care; increases the resident's knowledge of environmental nuances and themes, and to adapt treatment to meet the patient's needs in context of the patient's environment

Psychotherapy-Supervisor advances the resident's ability to understand the patient's functioning and needs and address them using psychotherapeutic modalities; is flexible in his/her theoretical orientation and psychotherapeutic modalities; helps the resident integrate psychotherapy with other treatment modalities

Psychodynamics-Supervisor advances the resident's ability to understand unconscious dynamics; use of defense mechanisms; transference and countertransference dynamics; use of psychodynamic interventions such as interpretation, silence, reflection

Psychopharmacology-Supervisor advances the resident's ability to select, prescribe, and manage psychopharmacologic agents; helps the resident increase his/her knowledge base about medications, indications, side effects, and subtleties of pharmacologic management; helps the resident learn the scope and limitations of psychopharmacology; helps the resident integrate psychopharmacologic practice with other treatment modalities
Research/Scholarship - Supervisor increases the resident's ability to assess the validity and quality of relevant research, and to integrate research findings into treatment; increases the resident's appreciation for the importance of empirically validating clinical practices whenever possible; helps the resident develop his/her own scholarly or research interests and abilities.
Please select the number that best describes the resident's ability in each of the following items.

Professionalism

1 = Poor
2
3
4
5 = Excellent
N/A

Systems-Based Practice

1 = Poor
2
3
4
5 = Excellent
N/A

Overall Supervisor Rating

1 = Poor
2
3
4
5 = Excellent

What did you like best about this Supervisor?

What did you like least about this Supervisor?

What recommendations do you have for this Supervisor?

Overall Comments:
**Interview skills**: Misses important information, poor rapport, misses emotional cues. Unaware of cultural and diversity issues. Judgmental. Unable to communicate diagnosis or treatment plan.

Complete, empathetic, non-judgmental, attuned to dynamic issues and nuances of behavior, thought process and content. Listens carefully, respectful of cultural/diversity issues. Communicates treatment plan effectively.

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**Case Presentations**: Incomplete, disorganized, superficial. Mental status does not identify pertinent information.

Concise, organized; thorough; pertinent positives and negatives elucidated. Uses recognized logical approach.

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**Fund of Knowledge**: Poor knowledge of diagnostic criteria, pathophysiology and therapy, including mechanisms of meds.

Extensive knowledge: knows pathophysiology and mechanisms of med. Able to develop complete diff. dx

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**Clinical Judgment**: Difficulty identifying pertinent clinical data or integrating clinical data with medical knowledge. Indecisive. Fails to prioritize patient problems.


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**Formulation of Problem/Treatment Plan**: Incomplete, not aware of social or medical issues that might complicate treatment and compliance. Does not utilize other resources in disposition planning.

Complete list of patient’s problems including psychiatric, psychological, medication, social and medical issues. Integrates into formulation/treatment plan. This through risks and benefits of interventions. Involves other resources in disposition planning.

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**Documentation**: Incomplete, illegible, not properly titled, dated, timed or signed. Not informative. Progress notes/discharge summaries not completed in a timely manner.

Complete, well organized, legible, concise, timely and reflective of patient’s status.

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**Effort to learn/initiative**: No evidence of or motivation for independent learning.

Self-directed, consistently demonstrates use of resources including tests, journals and MedLine. Initiates academic projects.

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**Professionalism**: Dishonest, defensive, disrespectful. Late, ineffective time management, misses meeting, not accountable. Does not answer pages. Inappropriate behavior or dress.

Respectful, effective time management, reliable. Committed to patient care. Maintains high ethical standards for self and others. Establishes trust with others.
Supervision: Defensive, does not bring issues to supervisor. Late, unprepared
Not defensive, asks for feedback, makes constructive changes in response to supervision

Interaction with System of Care: Difficulties with families, other disciplines. Easily frustrated with barriers to ensuring comprehensive care. Does not arrange or take part in family meetings
Respectful and compassionate with families and other disciplines. Ensures comprehensive care. Actively involved in family meetings

Boundary Issues: Intrusive, inappropriately personal or impersonal. Does not maintain appropriate doctor patient relationship
Able to maintain professional relationships and provides patient centered care

Leadership: Passive in situations requiring physician leadership. Defers to others to set agendas and solve problems. Ineffective in communication with others. Misuses authority over others
Active in recognizing and takes initiative in solving problems. Communicates effectively with others. Mobilizes appropriate resources. Uses authority constructively

Teaching: Makes no effort to include students. Does not teach effectively
Includes students, teaches effectively, mentors, acts as a role model. Brings in and cites literature

Comments: Please describe strengths and specific areas for growth and improvement

Assessment Sources
The validity of this will be enhanced if the checklists of these experiences are appended so do you want to expect that
• Direct observation of resident/patient interactions
  Yes  No  N/A

• Chart stimulated recall
  Yes  No  N/A

• Oral Presentation
  Yes  No  N/A

Number of cases assessed
Range from 1 to 100

Frequency of supervisor contacts

Comments

Remaining Characters: 5000

Direct feedback regarding evaluation has been given to the resident
  Yes  No  N/A

For Psychotherapy Supervisors Only:

Type of Supervision:

Brief
  Yes  No  N/A
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<th></th>
<th>Yes</th>
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<tr>
<td>CBT</td>
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<tr>
<td>Family/Couples</td>
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<td>Group</td>
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<tr>
<td>Other</td>
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<tr>
<td>Psychodynamic</td>
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<tr>
<td>Supportive</td>
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Were patients supervised on medications

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<th></th>
<th>Yes</th>
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**UNM Addiction Psychiatry Fellowship**  
**Annual Program Evaluation**

Responses should be based on ALL experiences thus far, and NOT individual experiences.

**Rating scale:**  
1 – Below minimum expectations  
2 – Meets minimum expectations  
3 – Sometimes exceeds expectations  
4 – Consistently exceeds expectations

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<tbody>
<tr>
<td>1. Appropriate level of patient care responsibility.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<tr>
<td>2. Availability of an appropriate amount of clinical cases within the psychiatry program.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>3. Amount of didactic sessions offered by the psychiatry program.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>4. Overall quality of didactic sessions offered by the psychiatry program.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Amount of supervision within the psychiatry program.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>6. Overall quality of supervision within the psychiatry program.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Quality of clinical staff within the psychiatry program.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>8. Quality of performance feedback given by faculty.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Program’s responsiveness to feedback from residents.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Overall satisfaction with the training I have received.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>

11. Would you recommend the UNM Addiction Psychiatry Fellowship to someone else?  
[ ]Yes  [ ]No

12. What do you like about our program?  
__________________________________________

13. What would you like to see improved in the program?  
__________________________________________

14. Additional comments regarding your training at UNM Addiction Psychiatry Fellowship:  
__________________________________________
**UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE**
**ADDICTION PSYCHIATRY FELLOWSHIP PROGRAM**
**360 EVALUATION TOOL**

Name of Fellow: ________________________________  Date of Service: ________________

Name of Person Evaluating: _______________________
Location: _____________________

As part of the Addiction Psychiatry fellows’ evaluations, they are evaluated by non-psychiatrist clinical and medical staff/colleagues with whom they have worked. Please evaluate the above named fellow for work done during the **past 6 months**. The evaluation you provide will be used by the training director to help the child psychiatry fellow in his/her professional development. Thank you for your help.

<table>
<thead>
<tr>
<th>How is the fellow at:</th>
<th>Unacceptable</th>
<th>Acceptable</th>
<th>Excellent</th>
<th>N/A</th>
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<tbody>
<tr>
<td>1) Relating to patient (overall)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- developing rapport</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- effectively listening</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- command of language</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- talking at appropriate language level for the patient/client</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- explaining conditions tests, meds, etc.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- discussing options</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- respecting cultural differences</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- maintaining boundaries</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- is comprehensive, considers age related concerns</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2) Relating to co-workers (overall)</td>
<td>1</td>
<td>2</td>
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<td>4</td>
</tr>
<tr>
<td>- working with other professional disciplines</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- understanding and respecting team roles, especially in geriatric roles</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- appropriately soliciting input from other clinical team members in decisions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- weighing others’ opinions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>- giving constructive feedback or criticism</td>
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<td>4</td>
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<tr>
<td>- respecting cultural or ethnic differences</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- accepting constructive feedback or criticism</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- communications appropriately with referring physician</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3) General Professionalism</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- responding to pages</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- following policies and procedures</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>- maintaining professional demeanor and appearance</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- respecting confidentiality</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- adhering to appropriate comments, including humor</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- maintaining appropriate boundaries</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- attempting cost effective practices</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- eager in self instructions and educates others appropriately</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
4) I would be comfortable referring family or friends to this doctor’s care.

<table>
<thead>
<tr>
<th>Never</th>
<th>Maybe</th>
<th>Probably</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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</table>

Any Additional comments would be welcomed:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Thank you for providing your evaluation of this fellow.

Please return form to: Andrea Chapman  
Medical Residency Coordinator  
MSC09 5030  
1 University of New Mexico  
Albuquerque, NM  87131  
(505)272-5002
University of New Mexico Health Sciences Center
Addiction Psychiatry Fellow Self Evaluation Form

RATING SCALE

S- Satisfied: I’m satisfied with my progress in this area
F- Focus: I’d like to focus more in making progress in this area and think I know how to do it.
H- Help: I’d like to focus more in making progress in this area and am not sure how to do it.
N/A - Not applicable

A. Patient Care
   1. Able to interview patients and get the information I need
      Rating: _____ Comments:

   2. Able to give oral presentations, including diagnosis and formulation
      Rating: _____ Comments:

   3. Able to prioritize treatment needs and establish a treatment plan, evaluate risk for harm, seek supervision when necessary
      Rating: _____ Comments:

B. Medical Knowledge
   1. Psychiatric knowledge is at the level it should be for my level of training
      Rating: _____ Comments:

   2. Medical knowledge is at the level it should be for my level of training
      Rating: _____ Comments:

C. Practice-Based Learning and Improvement
   1. Know how to apply EBM in the care of my patients
      Rating: _____ Comments:

   2. Take initiative to expand my knowledge and skills, know my own skills and limitations
      Rating: _____ Comments:

   4. Take leadership role, teach others
      Rating: _____ Comments:

D. Interpersonal and Communication Skills
   1. Good professional relationships with colleagues, support staff, treatment team, supervisors; can recognize when problems occur and resolve conflicts
      Rating: _____ Comments:

   2. Can manage work stress so that my professional functioning remains effective; recognize when I am fatigued and manage fatigue appropriately
      Rating: _____ Comments:
E. Professionalism
   1. Good work habits, medical records well done and done on time, seminar attendance is 70% or better
      Rating: _____ Comments:
   2. Able to recognize ethical issues and effectively resolve them
      Rating: _____ Comments:
   3. Able to recognize cultural issues in working with patients, and to adjust therapeutic interventions in response to cultural issues
      Rating: _____ Comments

F. Systems Based Practice
   1. Able to advocate for my patients and work effectively with other healthcare providers in the care of my patients
      Rating: _____ Comments:
   2. Aware of and able to provide cost effective care
      Rating: _____ Comments:

G. Psychotherapy
   1. Able to establish therapeutic relationship with a broad range of patients
      Rating: _____ Comments:
   2. Able to negotiate therapy goals with patients and their families
      Rating: _____ Comments:
   3. Able to conceptualize and formulate cases
      Rating: _____ Comments:
   4. Aware of different therapeutic modalities and when and how to implement them
      Rating: _____ Comments:

H. Individualized fellow goals
1. Date__________ GOAL:
   Plan to achieve goal:
   Progress in achieving goal:

2. Date__________ GOAL:
   Plan to achieve goal:
   Progress in achieving goal:

3. Date__________ GOAL:
   Plan to achieve goal:
   Progress in achieving goal:

Fellow's Signature:_______________________________________________________
Date:____________________________________
Reviewed with Advisor:
Advisor Signature: ____________________________
Elective Rotation Proposal

Addiction Psychiatry Fellow: ________________________________

Dates of Elective Rotation: ________________________________

Proposed Mentor: ________________________________

Proposal (must include scholarly activity. If a clinical rotation, include literature review, small survey, chart review, etc):

Desired Outcome:

Proposed Documentation of Outcome (e.g., case report, presentation, grand rounds, etc):

____________________________________________  ______________________
(Fellow’s signature)  (date)

___________________________________________________
(Mentor’s signature)  (date)

___________________________________________  _______
(Approval signature of Training Director)  (date)
ADDICTION FELLOW LEAVE REQUEST FORM

Name: __________________________________________ Date:

Type of Leave (check one): ___ Annual ___ Professional (interviewing)
___ Sick ___ Educational (conferences, exams, etc.)
___ Other (specify) __________________________________________

Time of Leave: from _______________ Date

Time

through _______________ Date

Time

Total WORK Days Absent: _______ Total WORK Hours Absent (days x 8): _______

Destination and Purpose of Educational Leave:

________________________

COVERAGE:

Program/rotation Covering Clinician(s)

1) ____________________________

2) ____________________________

3) ____________________________

4) ____________________________

APPROVALS:

Primary Attending __________ Date _______

Director of Training __________ Date _______

Fellowship Coordinator __________ Date